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Group Hospitalization—Mecca or Mirage?

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THE present widespread interest in group payment for hospital service—voluntary hospital insurance—is not accidental. It is fundamental. For several years the difficulty of the hospital in collecting patients' fees and the difficulty of the individual patient in paying for hospital service have suggested the need of stabilizing hospital revenue.

Group hospitalization plans have been instituted or are in contemplation in a number of cities, among them Dallas, Fort Worth, San Antonio, Shreveport, Louisville, New Orleans, Colorado Springs, Pueblo, Newark and Elizabeth, N. J., New York City, Philadelphia, Brattleboro, Vt., Grinnell, Iowa, and Rockford, Ill. The following discussion will be based upon the experiences and special features of the various types of group hospitalization schemes represented in these cities.

The explicit recommendations of the Committee on the Costs of Medical Care in favor of voluntary hospital insurance will undoubtedly give impetus to the study and development of such plans. From the standpoint of the hospital patient, the plan of ensuring the payment of his hospital bill through fixed monthly dues removes the uncertainty of such costs and of the ability to meet them.

It is not the purpose of this article to discuss the theoretical advantages and limitations of group hospitalization to the institution or the patients. The experiences of hospitals that have instituted the plan show that each hospital must solve its own problems with regard to such features as the monthly or annual premium, the type and scope of medical benefits and the enlistment of support by medical practitioners. The unanimous testimony of hospital administrators who have experimented with the group payment plan appears to be about as follows: Physicians ultimately, if not immediately, recognize that group hospitalization increases the possibility of collecting a reasonable medical or surgical fee. Patients and physicians do not abuse the privilege of free hospital service merely because it is paid for in advance. The receipts for premiums exceed the fees which probably would have been collected from the same individuals for the same amount of hospital service. The increased revenue to the hospitals from group hospitalization exceeds materially the increased expense from serving such subscribers.

On the following pages I wish to consider certain practical administrative features of putting a group payment plan into operation, assuming

that it is regarded as theoretically sound and socially desirable from the standpoint of a particular institution. The following points will be presented in order: (1) relative merits of individual against group policies for subscribers to the plan; (2) comparative advantages of one as opposed to several participating hospitals; (3) proprietary *versus* nonprofit promoting and administrative organization; (4) relations with medical staffs; (5) scope of hospital benefits; (6) types of illnesses covered; (7) methods of remunerating participating hospitals for services to patients; (8) legal aspects of group hospitalization.

Large Group Contracts Are Best

By group hospitalization is meant a plan by which a large number of individuals contribute equal amounts to a common fund which is to be used for purchasing hospital service for members who require it. Ordinarily hospital service applies solely to the care of bed patients (excluding outpatient care), and has no connection with fees to, or the professional services of, attending physicians or surgeons. The hospitals individually or as groups guarantee to provide medical service under the terms of the contract regardless of the amount of premiums collected; all premiums or dues paid by subscribers are paid to the hospital or hospitals, regardless of the amount of service rendered. Group hospitalization of this type is to be distinguished from arrangements by which private clinics or private insurance companies collect premiums or dues. The private clinics or commercial insurance companies either pay to the policyholders fixed daily sums, regardless of the hospital bill, or make cash payments to the hospitals for services rendered according to a basic fee schedule. Plans of the latter type are in effect in Little Rock, Los Angeles, San Diego, Portland and Seattle, to mention a few cities.

A group hospitalization plan should center its emphasis upon group insurance agreements rather than upon contracts with separate individuals. The sale of a hospitalization contract to an individual involves high sales expense, high cost for office administration and bookkeeping and a repetition of sales effort at the time of the renewal of each policy. When individual contracts are offered it is usually the more sickly who are most apt to recognize the benefits of the plan. Consequently the subscribers include a relatively large number of "bad risks" from the financial point of view.

Another difficulty with individual contracts is that policyholders are not previously known to or acquainted with each other. Consequently even though hospital benefits are received by a reasonable proportion of the subscribers, these facts are not known to other policyholders in the same way as if they were members of the same industrial, social or political group. It is a good idea for Mr. Jones to know when his fellow employee, Mr. Smith, goes to the hospital as a beneficiary of the group hospitalization plan. The psychological effect of observing one's neighbor receive hospital benefits under the plan is lost when the individual subscribers are not known to each other.

When group policies rather than individual policies are written, one sales effort suffices to enroll a number of people employed by a factory or mercantile enterprise. The members of the group talk the plan over among themselves, and the individual subscribers consciously or unconsciously influence others to increase the membership. Collections for a group may be made through an employer or through the secretary of an employees' association. Renewals for the group do not require solicitation. They may be handled through the device of merely allowing subscribers to continue to pay subscriptions, in advance, for the period of time to be covered.

The most satisfactory groups for hospital insurance are obviously the large ones because of the reduced office expense for bookkeeping concerning the collection of dues. The subscribers should also be more or less homogeneous in social and economic status, so that individuals will agree in their appraisal of benefits received. The employees of a factory or members of a trade union "local" would be particularly satisfactory in this respect.

Individual Policies More Risky

It is especially desirable that relatively high proportions of each group be enrolled as subscribers. The hospitals should insist, if possible, that at least 50 per cent of any group applying for group hospitalization benefits should subscribe for and join the plan. In this way "adverse selection" of subscribers would be avoided. An unduly high proportion of "bad risks" might cause either a loss to the hospitals or an increase of premiums to the subscribers. Special discounts from the standard "dues" may be allowed for large groups, and for groups in which a high percentage of the eligible members became subscribers.

Individual policies can be made acceptable in some instances by requiring a physical examination or a waiting period before a subscriber is entitled to hospital benefits. Individual memberships should also carry larger premiums and should be payable on a semiannual or annual basis. Moreover, individuals should probably be accepted only upon application rather than being aggressively solicited. By such arrangements as these the individual subscribers can be accepted without

jeopardizing the financial stability of the plan.

Should a single hospital attempt a group hospitalization plan or should it participate with other local institutions? This question cannot be answered categorically. A single hospital would of course receive more revenue from group hospitalization if it were not required to share with others in the payments on behalf of sick subscribers. On the other hand, the total number of subscribers would probably be greater if several institutions participated in the group hospitalization scheme.

Cooperative Plan Is Preferable

For one hospital to succeed with group hospitalization, it should maintain an open medical staff. Even then, unless attending physicians preferred the particular hospital sponsoring the plan, the scheme might be hindered materially through public opinion and the opposition of the medical profession.

Participation by a group of hospitals is, in general, preferable from the public as well as from the professional point of view. Such participation is necessary if the patient is to have reasonably free choice of a physician at the time of hospitalization.

There is nothing about the joint action of several hospitals that would interfere with existing professional or personal privileges in the respective institutions. Group hospitalization would not compel a hospital to allow a physician to attend a subscriber unless such physician were a member of the attending staff or courtesy staff for the type of service required. Nor would it be required for a hospital to accept a patient unless the subscriber were eligible, under ordinary conditions, for the services and type of accommodations required.

Physicians and patients naturally would prefer some institutions to others, a preference that now exists in any community. Subscribers and physicians would use those hospitals which, in their opinion, provided the greatest benefits in exchange for premiums paid. It would be assumed, of course, that the benefits were identical in all institutions, that is to say, all institutions would provide nursing service and special services under the same conditions and with the same restrictions.

A group of hospitals could among themselves provide the working capital for a group hospitalization scheme. This burden conceivably might deter individual institutions from initiating the plan. To be sure a commercial agency might offer to finance such a plan, either at the outset or permanently.

Should the initiation and administration of a group hospitalization plan be carried on directly by the participating institutions, or should such responsibilities be delegated to a separate enterprise organized for profit? The answer lies in the comparative economies of the two methods, having in mind such factors as the availability of an efficient executive or salaried manager, the source of original working capital and the probable expenses of bookkeeping and administration. One thing is clear. The method of promotion must be such that no individual or group of individuals can gain personally through the decrease or restriction of the medical services required by the subscribers. The payments to the participating hospitals must be a definite total sum irrespective of the total volume of service required from them. Payments to employees or middlemen must not be allowed to influence the amount and quality of medical services rendered.

Most of the contractual arrangements have been effected through agencies that receive a definite commission on the premiums collected. This stated commission avoids the danger of the promoting agency's attempting to influence payments out of the common fund to the individual participating hospitals.

The question of the desirability of using a proprietary sales and administrative agency for group hospitalization is not to be settled on mere theory. It is a practical problem for each group of hospitals to consider along the following lines: Could the group of hospitals through their own organization with employed executives protect their own professional practices in the community more satisfactorily than a commercial sales agency? Could a nonprofit association of the participating hospitals develop as large and as economically desirable a total of subscribers as the middleman?

The Administrative Costs

With regard to the first question, the scale would appear to tip in favor of the hospital's own organization. With regard to the second question, matters of local custom and available personnel would be the immediate deciding factors. The special qualities of the private promoter may make him admirably suited to introduce the group hospitalization plan to employees and groups of employers in any particular community. On the other hand, the employment of a paid executive by the hospitals themselves might involve lower overhead costs with equally satisfactory results.

It has been customary for proprietary agencies to receive for their services from 30 to 40 per cent of the premiums collected. Some agencies have arrangements by which lower percentages are received after a twelve-months' period from the enrollment of the respective individual or groups

of subscribers. Usually 10 per cent is paid as a commission to the salesmen, and from 20 to 30 per cent is used for administrative costs, office upkeep and profit. A financially sound enterprise sponsored by a group of hospitals probably could in many instances reduce the proportionate overhead costs, and in this way offer the service at lower premiums to patients or make possible higher payments to the participating hospitals. It is possible also that a nonprofit organization may receive more favorable publicity in the local press, as well as economically valuable support from influential citizens, particularly hospital trustees.

Help of Medical Staff Needed

The promotion of a group hospitalization plan must be aggressive. The public will see the theoretical advantages but will be suspicious of the practical workings. Some people still remember various fly-by-night attempts at group hospitalization which have been promoted on unsound financial bases during the past twenty years. The benefits must be explained clearly and continuously to groups of prospective subscribers. Such promotion costs money, and must be paid for directly by the hospitals and indirectly by the patients. It is for each community to decide whether it is more desirable immediately and in the long run to form a nonprofit organization to promote voluntary hospital insurance, or to turn the financial and administrative responsibilities (as well as the opportunities for gain or savings) to proprietary middlemen.

The medical staff of any particular hospital should, of course, be sympathetic to group hospitalization if the plan is to be launched under the most favorable auspices. It is important that a hospital director participating in such a scheme explain the idea and workings of group hospitalization, so that physicians may aid in establishing proper attitudes among actual and prospective subscribers.

A doctor would in most instances find it easier to collect a reasonable fee from subscribers who became his patients than from the same persons if they were required to pay hospital bills from their private resources. Moreover, the doctor is given reasonable freedom in ordering diagnostic services according to the patients' needs, knowing that certain of these services will require no extra cost.

The personal relations between physician and patient would not be affected by group hospitalization. The patient would tend to be served in the hospital preferred by his physician, and the physician would have the same privileges with regard to certain types of medical service that he enjoys in the treatment of other cases. Group hospitalization would neither help nor hinder the activities of a physician with no existing hospital appointments. It would, of course, be a disadvantage to doctors whose hospital appointments were exclusively in institutions not participating in the group payment plan, for patients would be accepted by the hospitals only when attended by physicians eligible to serve in the respective institutions.

A question arises concerning the care of patients who are unable to pay physicians' or surgeons' fees, even though the group hospitalization dues would remunerate the institution for the hospital benefits. This situation would remain the same as at present. A physician bringing his patient to the hospital would know in advance whether or not he intended to make a charge for his services. The doctor would make his choice of serving this patient personally on a no charge basis or referring him to members of the attending staff who were "on service" for nonpaying patients.

The amount and type of hospital benefits will vary with the premium to be charged and vice versa. Group hospitalization plans have ranged in their fees from $6 to $12, and in their medical benefits from twenty-one days board and room and the use of the operating room only, to thirty days complete hospital care, including unlimited x-ray and laboratory services, as well as blood transfusions. The scope of the benefits and the annual premiums must be decided on the basis of estimated future expense and the psychologic effect of certain inclusions or exclusions. In general, it seems that the additional charge necessary for certain special benefits, such as x-ray, are more than offset by the sales appeal attendant upon offering an inclusion of these with very few exceptions. The benefits should in every instance include the basic necessities that most patients require, such as a certain number of days of board and room service and the use of the operating rooms.

The Matter of "Extras"

With regard to special services, such as x-ray, laboratory, basal metabolism tests, physicians may vary in their professional judgment as to the necessity of these procedures in a given case. One of three financial policies may be adopted by the participating hospitals with regard to these so-called "extras." (1) The premium may be increased sufficiently to cover the estimated total costs of special services, assuming there will be some "unnecessary" work; (2) special services may be offered to subscribers at a proportionately reduced rate, regardless of the amounts purchased; (3) special services may be charged at standard rates with an agreed maximum total fee regardless of the benefits received. Each of these three poli-

cies has been adopted with success in different institutions. The first of them would appear to be most satisfactory from the point of view of subscribers, even though it may result in a higher total monthly payment by each member of the group. In this way the costs of the more expensive illnesses would be distributed over all subscribers rather than centered upon those requiring hospitalization.

Certain Illnesses Usually Excluded

Group hospitalization is most useful and most needed in the care of acute and unpredictable illnesses of relatively short duration. These include all forms of accidents and functional disorders requiring bed care or surgery. It is common for group hospitalization plans to exclude illnesses which are chronic, predictable or avoidable. The expenses of such illnesses are borne by taxes or are thrown back on the individual as "punitive damages." Usually chronic diseases, such as tuberculosis, mental diseases, arthritis and cardiac troubles require bed care only in their last stages and at a time when the patient himself is not a self-supporting member of his own community. Predictable disease, more or less within the individual's control, such as alcoholism, venereal disease, willfully self-inflicted injuries and pregnancy, must be treated by office care in the early stages and require bed care only under conditions that can be foretold several months in advance.

The exclusion of tuberculosis, mental disease and venereal diseases does not mean that such cases should not be covered through group payment, but rather that they should be made the responsibility of an entire community rather than of a particular small group in which the proportion of individuals suffering from these conditions would not be uniform. It is customary for subscribers to group hospitalization plans to receive special discounts for maternity service and for the treatment of willfully self-inflicted injuries. The hospitalization of infectious cases is usually excluded, as being more appropriate for provision in local governmental institutions.

In determining the methods of payment by individual subscribers a choice must be made between frequent payments which minimize the financial burden upon the subscriber and infrequent payments which minimize the bookkeeping for the receipt of funds by the participating hospitals. It is particularly desirable that any unpaid installments be demanded at the time a subscriber receives medical services and that he be required to pay in full for the entire fiscal period, usually a year, during which he receives any or all of his hospital benefits. The determination of the fiscal year may provide for a twelve-month period from the date of enrollment or a date from some particular day of the year for all patients, such as January 1 or July 1.

Payments to hospitals on behalf of subscribers admitted for service should insofar as possible be on a flat rate all-inclusive basis, with no extras. This should mean that a hospital would receive no more cash for a case which required a great deal of special service than for one requiring only board and room care. Consequently some cases would be relatively more profitable to the hospitals than others, but in the long run the income to the hospitals would be balanced according to the amount of service rendered.

The amount of the daily payment to the hospital will depend upon previous agreement and will be influenced by the size of the monthly premiums. The daily allowances might deliberately be set at a figure lower than that estimated to consume the entire premiums, with a provision for periodic distribution among the participating hospitals according to days of care rendered. For example, the immediate payments to hospitals might be $3, $4 or $5 a day, even though the dues would have been sufficient to pay at the rate of $8 a day of care.

An agreement would also be necessary for a pro rata reduction in the daily payments to hospitals in case an epidemic or other calamity required the acceptance of an unusually large number of subscribers. Usually the conditions increasing hospital admissions would not apply to all subscribers at once or to subscribers only. An accident would not affect all subscribers; likewise an epidemic of influenza would not be limited to them. The increased admission of subscribers suffering from an epidemic disease would be attended by increased income from private patients and a lower per capita operating cost from increased utilization. The reduced proportionate payments to participating hospitals on behalf of subscribers would therefore not be a total loss to the institutions.

Privileges Not Generally Abused

The economic effects of a group hospitalization plan must be determined by comparing the receipts on behalf of subscribers with any of the three following amounts: the prices ordinarily charged for the services received by the individual subscribers; the per capita costs of the institution as a whole; the additional costs entailed by services to subscribers. The last mentioned amount—the increase in the total hospital expense budget—is, of course, the basic figure against which each hospital should compare receipts on behalf of hospitalized subscribers. Most hospitals have found and probably will find that the revenue received from

group hospitalization is greater than that which would have accrued to the hospital for the same services to the same patients.

It may be feared that patients and attending physicians will demand unnecessary services. This possibility, although a real one, has not proved to be serious in practice. In the long run both physicians and patients have shown a desire to limit hospital benefits to those necessary to good medical care and have not abused the privileges to which they were entitled.

Legal Advice Should Be Sought

As ordinarly set up the agreements represent "contracts" by the hospitals, individually and severally, to render certain professional "services" and not to pay or to guarantee to pay certain amounts of "money." Consequently, in several states group hospitalization has not been regarded as coming under the insurance laws, but has been regulated by the common law regarding contracts of service. The responsibility to render service rests upon the hospital which accepts the individual subscriber, and the service must be rendered by the hospital regardless of whether it is paid for by the central fund. If facilities are not available in one institution, because of crowded conditions or medical policy, the responsibility shifts to another hospital. In case all hospitals are occupied to capacity the association may discharge its responsibilities by paying a specified sum, such as a multiple of the annual premium, to each patient requiring hospitalization during the period.

Hospitals contemplating group hospitalization plans should seek legal advice on the organization of such schemes. Further discussion of this point will be presented in a subsequent article.

Skillful Management Is Required

Group hospitalization is economically sound in practice. The group payment plan provides an equitable distribution among subscribers of the costs of hospital care. The revenue from subscribers tends to stabilize and increase a hospital's income from patients of limited means. The promotion and management of a group hospitalization scheme, however, are not simple procedures and should not be embarked upon in a light-hearted manner. They require careful study and skillful management. They require an understanding of the problems of professional relations with physicians, of community relations with patients and of the economics of hospital service. Properly planned and managed, group hospitalization may be a genuine economic benefit both to hospitals and to the public. Its development throughout the country and in particular localities will depend upon the foresight and administrative skill of hospital superintendents and trustees.

In a subsequent article, will be presented further detailed discussion of group hospitalization, addressed to the following questions: What occupational or age groups tend to be the best risks? Should family members be enrolled? How can the hospital service be estimated? How can a reasonable premium be established? Should subscribers be allowed to retain membership while unemployed? Does group hospitalization come under the insurance laws of the various states? The answers will be based upon statistical data obtained from the Committee on the Costs of Medical Care and the experiences of the individual hospitals with group hospitalization.

A Provident Hospital Scheme for the Middle Classes

Steps have been taken in London, England, to provide hospital and medical service at reasonable cost to persons of the middle classes. Many persons in the middle classes are in the unfortunate position of not being subjects for the free medical and hospital treatment available to the poor, nor are they able to bear the great cost of sickness as the wealthy can.

As a remedy for this evil the British Provident Association has been formed. Its purpose is to provide hospital and nursing home beds at reasonable charges and covering substantially, if not wholly, the cost of maintenance during the illness and the surgical fees. The association will attempt to secure $50 each from 100,000 persons. This money will be used to provide 1,000 beds in the existing voluntary hospitals or in new buildings, which will be known as the association's "home hospitals."

The proposition was discussed at a recent meeting of the association in London, under the presidency of the lord mayor of London. It was estimated that there are in greater London 600,000 families (two and one-half million persons) belonging to the middle and professional classes, any of whom might at one time or another be in need of hospital accommodations for serious illness. At the present time the voluntary hospitals of London have 1,500 beds available for such a purpose, but more are needed.

While a payment of $50 will provide the benefits for a man and his wife and children up to the age of twenty-one years, it has been decided to accept $25 from single persons who are unable to pay the full amount.

A Hospital That Features Hospitality

By RAYMOND P. SLOAN
New York City

ITS location in one of New York City's most congested districts, where it conducts an out-patient department that handles approximately 650 clinic cases daily, has not prevented the New York Polyclinic Hospital from surrounding itself with all the atmosphere of a modern, well equipped hotel.

Founded in 1881 as the New York Polyclinic Medical School and Hospital, the institution is today frequently referred to by those it has served as "Polyclinic Hotel." This in itself is proof of the progress made over a span of fifty-one years in featuring hospitality as part of hospital routine.

Even the entrances to the hospital dispel depression and gloom. The main building, a twelve-story structure, and also a new eleven-story addition, seven floors of which will be devoted to teaching purposes and the care of out-patients and four floors to private patients, carry with them the businesslike air of a modern hostelry. The private pavilion, reached from an adjacent street, resembles a fashionable apartment house, with its main corridor decorated in Spanish style and lined with comfortable divans and chairs. Oil paintings adorn the walls and imported vases and lamps further create the illusion of an entrance hall in some fine home. All suggestion of sickness is relegated to the background. The visitor's first impression is of beauty.

This impression grows upon further investigation, and culminates in the effect that greets the visitor as he steps off the elevator on the twelfth floor. Here is the hospital's latest achievement in affording a luxurious solarium for convalescents —the Chinese Lounge.

Surely nothing could be further removed from the proverbially gloomy surroundings within hospital walls than this gay bit of Chinese garden, planned by A. A. Jaller, executive officer of the institution, who was solely responsible for the design and decoration. The lounge has been thrown open only lately for daily use by the private patients. Through an archway gaily decorated in red and black, with inserts of gold carving, a glimpse is afforded of typical Chinese landscaping. Above the entrance door in bold Chinese script is the word "Welcome."

Two life-sized Fu dogs guard the portals, fulfilling their traditional function of warding off all evil spirits. Essentially Chinese, too, is the sen-

timent inscribed on the walls behind them, which as translated reads: "When the medicine takes effect, the spring returns."

Along the entire length of the room are windows equipped with glass that transmits the ultraviolet rays of the sun, and sunlight streams down upon wicker chairs and lounges of Chinese design, the upper casement fretwork casting truly oriental shadows on the strip of velvet carpet that covers the center aisle. Taborets of teakwood imported from China hold ash trays and smoking equipment.

The Shrine of the Priest

Black and red are the colors that predominate on the walls, the ceiling and the tile floor, these colors being pleasingly varied with black and gold panels inserted on the walls and with artistically executed panoramas of Chinese scenery, painted in soft colors.

On one side a wistaria vine climbs from a Chinese vase on the floor up to a lattice, winding its way along the roof of a pergola. Beneath stands an old Chinese booth, over one hundred years old, exceedingly beautiful with its hand carving and richness of detail. Another genuine antique is the Shrine of the Priest, reached by a little bridge built over a fish pond. By its side a brook trickles gaily down between rocks, starting from a mountainside depicted faithfully in a wall painting. Goldfish large and small flash to and fro in the pool at the bottom, their movements guarded jealously by two bronze herons.

Overlooking this scene is the figure of Ho-Tai, the God of Happiness, while from her ornate pedestal the Goddess of Mercy smiles beneficently. Everywhere are cheer, hopefulness, an atmosphere of well-being and health.

Lighting is concealed below the painted panels so as to bring out their full decorative effect. Fixtures designed in true Chinese lantern style hang from the ceiling. Soft music may be heard above the trickling of the mountain stream. It comes from a radio cabinet finished in the prevailing red and black. Even the piano and telephone are similarly decorated.

The room is presided over by two Chinese girls attired in their native garb. Each afternoon at two-thirty, a gong sounds, announcing the start of tea hour. From a pantry installed in the rear, red lacquer tea wagons are then rolled, laden with tea, chow mein and Chinese delicacies. The convalescents are served on china especially designed and executed in black. When the plates are removed a souvenir in the form of a Chinese doll or fan is left with the visitor as a token of his visit.

The idea that prompted the introduction of the Chinese Lounge was a natural outcome of the

Ample window space, harmonious decorations carried out in soft shades of tan and green with numerous homelike touches characterize the private rooms. The balconies are made pleasant in summer by gay Spanish awnings.

A rustic bridge leads to the Shrine of the Priest where alongside a brooklet which trickles between rocks into a crystal pool, patients and their guests are served tea each afternoon. Two Chinese girls in native garb do the serving.

great success of Polyclinic's marine roof. This retreat for convalescents last year aroused wide comment as an interesting innovation in modern hospital luxury. It resembles a ship's deck in every detail, with its deck chairs, wireless, radio and deck games. To furnish authentic atmosphere, an orderly dressed in steward's uniform is in constant attendance. Each afternoon tea is served to patients and their visitors.

This attractive feature proved exceedingly popular during the summer months, so popular, in fact, that the need became apparent that something should take its place during the winter season. This led to the idea of a Chinese garden, whereupon the hospital's staff of carpenters and painters was put to work at once, under Mr. Jaller's supervision. The only outside talent employed was the scenic artist who painted the wall panels.

To these unique lounging quarters Polyclinic's private patients are brought from rooms equally luxurious in every detail.

"It may be called mental science," Mr. Jaller explains, "but everyone knows that surroundings affect one's spirits. That is why, after the new wing was finished, we decided to give it the appearance of a hotel rather than a hospital, in its decoration and furnishings."

Many little touches make Polyclinic's rooms "different." Soft shades of tan and green are used in the decoration of the walls. When green is the background every appointment is worked out in close harmony. Beds are of birch with rich covers of tan or green, made even more effective by contrasting borders. Fine etchings on the walls take away the bare look so common in hospital rooms. On the floor is rubber tile, carefully selected for design and color, and further softened by small hook rugs which fit into the general color scheme. Chairs are likewise of birch, upholstered in materials soft to the touch and pleasing to the eye. Even a chaise longue is provided as a welcome change from long days spent in bed.

Each room has its own desk. At one side of the bed an exquisite hand-painted screen introduces an added bit of color. Vases imported from Hungary and Italy provide a homelike touch, and copper receptacles make it possible to arrange flowers to the best advantage.

In each closet are a bridge table and four chairs, all ready for a friendly game when the patient's condition permits. Bathroom floors are furnished with chenille rugs in soft colors.

Each of the rooms has ample window space, affording in some instances an unobstructed view

Through windows extending the entire length of the lounge, sunlight streams upon furniture of Chinese design. Red and black is the main color scheme, interspersed with black and gold panels.

of the Hudson River. Windows are all equipped with ultraviolet ray transmitting glass. Many rooms have their own private balconies, easy of access in good weather. In summer, they are made even pleasanter by gay Spanish awnings.

Nor is this hotel air confined exclusively to the quarters occupied by private patients. Wards, too, have been decorated in soft colors, and further enhanced with framed etchings to make the patient as contented as he would be if he were in his own home.

The corridors in the new building are brightened by potted plants and occasional colorful pieces of imported pottery. Large aquariums in which goldfish swim happily, provide amusement for the patient who seeks diversion from his suffering.

"The idea is to make the hospital look like a home or a well equipped hotel—a hospital that suggests health, not sickness," in Mr. Jaller's own words. "We are after comfort, beauty and happiness. Cheer has replaced fear."

Perhaps even more descriptive of the spirit of hospitality that pervades the entire institution is the card of greeting the patient finds beneath the glass on his desk. It reads as follows:

"While you are under our care we wish to make you as comfortable as you would be in your own home.

"We aim to give you the utmost in service—

"We want you to be happy—

"We want you to get well as soon as you can.

"Please remember that this is your home while you are with us—

"We have tried to make your room cheerful.

"If there is any little thing we can do, please call upon us."

Special Rates Help Private Nurses

A special rate for patients employing private duty nurses was recently placed in effect at Prospect Heights and Brooklyn Maternity Hospital, Brooklyn, N. Y. The new rate will benefit patients of moderate means and also is expected to help relieve the unemployment among special nurses which is so prevalent.

When one special nurse is employed by the patient the hospital board bill will be reduced one dollar a day, and if two nurses are employed two dollars will be taken off the patient's bill for each day that the nurses are employed.

Our Changing Hospitals: 1883-1933

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SO MUCH that is new has found a place in hospital administration and in the social relations of hospitals during the past fifty years that sociologists and hospital administrators today are groping for an adequate description of the hospital, for a clearer definition of its place in the existing social order. I shall try to present a moving picture of the functional character and social relations of our changing hospitals during the period named. With each revolution of the reel a new phase of hospital development is thrown on the screen. The final phase reveals an institution of bewildering complexity, undergoing constant changes in function due to advances in scientific medicine, to new conceptions of social responsibility, to changes in social structure.

Phases of Hospital Development

I. The sole function of the hospital is the care of the sick. Primarily the hospital undertakes to provide medical and nursing care for those whose incomes are insufficient to enable them to procure such care for themselves. The public hospital, an offshoot of the county poorhouse, is a hospital for the poor exclusively. The voluntary hospital is a hospital for the poor chiefly; as a charitable institution performing a quasi-public function it is entitled to the sympathetic encouragement of the state and perhaps to a slight measure of state aid. Direct aid is in fact given to voluntary hospitals in certain localities in the form of modest public appropriations; voluntary hospitals are also assisted indirectly by the exemption of their property from taxation. Church affiliations of hospitals show that in the establishment and support of many hospitals religion is a potent influence. In the creation of nonsectarian voluntary hospitals the charitable impulse predominates; the initiative is, however, often supplied by ambitious surgeons whose motives are not entirely unselfish. The relief of the individual sufferer is the goal of hospital effort and little if any thought is given to comprehensive community plans of medical and nursing service.

II. In actual practice, the care of the sick continues to be the principal function of all hospitals and the exclusive function of most, but thoughtful commentators now assign to hospitals two additional duties: the education of physicians and the investigation of disease, and the acceptance of these responsibilities causes the pathologic and bacteriologic laboratory of the hospital to become increasingly conspicuous. Hospitals associated with medical schools strive to adjust their clinical organization to the requirements of clinical teaching, and find it logical and advantageous to couple investigation with teaching. The scientific aims of teaching hospitals begin to infect hospitals unattached to medical schools and there is some rivalry between the two groups.

Systematic efforts are begun to break down the popular prejudice against autopsies; the rate of autopsy consents rises from 8 per cent to 10 per cent to 50 per cent, 60 per cent and in some instances to more than 80 per cent, and a serious obstacle to the study of pathology accordingly disappears. Dispensaries increase so rapidly in number and in the scale of their operations as to cause murmurs in medical circles against the pauperization of the populace and the impoverishment of the medical profession. Administrators urge the unification of in-patient and out-patient departments, hoping thereby to avoid the costly repetition of diagnostic procedures, and to bring about a logical and effective continuation of treatment as patients pass from one division to the other. The principles of hospital planning are intensively studied and foundations are laid for a distinctively American system of hospital planning and construction which stresses nursing needs and emphasizes the economic importance of time and distance factors in the performance of clinical functions and of hospital service generally.

III. Hospitals, becoming self-analytical, learn that the investigation of disease by clinical and laboratory methods exclusively leaves untouched many relevant problems. Questions are raised about the fate of discharged hospital patients, the disappointing course of convalescence when associated with poverty, the disastrous effects of inadequate provision for chronic cases, the fallacy of a therapeutic method that relies wholly on prescription writing, the influence of economic and environmental factors in the causation, prolongation and recurrence of disease. Medical social service makes its first public appearance in the modest garb of a voluntary auxiliary hospital

service, but soon takes its place as a recognized part of routine hospital procedure. The use of drugs in dispensaries declines appreciably. Social workers report that the incomes of many working class families are insufficient not only to enable them to purchase adequate medical and nursing care but to permit them to maintain standards of living consistent with health.

The public ignorance of disease and of methods of disease prevention is noted, and hospitals accordingly undertake the hygienic training of certain types of patients, chiefly through medical social service, in addition to their treatment or cure. Occupational therapy is incorporated in the hospital program. The hospital is now squarely committed to the study of disease not only at the bedside, in the out-patient department and in the laboratory, but also in its environmental aspects or social background. In the department of nursing the teaching of pupils becomes more systematic, the curriculum expands, full-time instructors, trained in pedagogic methods, are employed, a course of instruction extending over a period of several months precedes the student's assignment to ward duty, hours of ward duty are decreased, study hours are increased and the clinical work of student nurses is more carefully supervised.

Maintenance Costs Rise

IV. Voluntary hospitals generally and municipal hospitals in certain localities are now patronized freely by all social classes, and as the proportion of private or paying patients increases, the earnings of hospitals mount rapidly. Luxuries and refinements originally introduced to satisfy well-to-do patients create standards of comfort which in part are applied to the public wards. Specialists strengthen their hold upon the medical organization. Studies in metabolic diseases react upon the department of dietetics, to which greater importance is attached. Radiography, radiotherapy and physiotherapy claim heavy tribute in space and equipment. The blood donor, originally a rare visitor and a devoted volunteer wearing a romantic halo, becomes a costly professional.

The widening of the hospital's program and the intensive development of its clinical, laboratory, nursing and educational activities greatly increase maintenance costs. The average duration of hospital treatment is greatly diminished, and the more rapid turnover contributes its share to higher maintenance costs. The ratio of employees to patients changes from 1:1 to 1.50:1, and in some cases even to 2:1 or more. Expenditures increase so rapidly that a demand arises for systematic budgeting and for standardized systems of accounting. The daily charge to paying patients, originally an inclusive charge, is supplemented by a system of extra fees for special services which can be easily isolated and measured. In this way many hospitals succeed in making their x-ray and laboratory departments self-supporting. The absence of common usage in classifying and naming diseases makes it difficult to compare the morbidity and mortality tables of different hospitals intelligently and efforts are made to bring about the adoption of a universal nomenclature.

Value of Concerted Action Is Recognized

V. The enactment of workmen's compensation laws makes industry responsible for the cost of hospital service in the case of accident or disease arising out of industrial employment. For a time rates of compensation for hospital care are determined arbitrarily or are fixed by agreement between individual institutions and insurers. Insurance carriers in some localities seek to increase their profits by claiming the benefit of public ward rates. The question arises whether public or quasi-public hospitals can properly accept compensation cases at less than actual cost, and hospitals in various parts of the country unite to express by joint action their demands for adequate pay. The value of concerted action by hospitals where their common interests are threatened by legislation or by unwise community action is more plainly seen, and new state and regional hospital associations and county and municipal hospital councils arise. State and county medical organizations negotiate with insurance carriers and with state boards and agree upon professional fees to be charged in compensation cases. Certain industries, among which the mining, transportation and lumber industries are conspicuous, organize complete medical services, hospital care included, for the benefit of their employees; industrial hospitals, originally paid for by corporation funds, are supported wholly or mainly by systematic weekly or monthly payments which are deducted by the employer from the wage of the worker.

VI. Great national organizations of physicians and surgeons interest themselves in phases of hospital practice which involve the moral integrity or technical proficiency of the profession. Hospitals are invited to scrutinize their work from these standpoints, to make periodic reports of progress and to submit to classification or grading. To these well intentioned demands, devised for their improvement, hospitals cheerfully conform. The periodic clinical conference becomes a routine hospital procedure. Improvements follow in low grade hospitals in clinical recording, in laboratory equip-

ment, in therapeutic equipment, in the observance of ethical rules of practice, in the training of interns. The minimum standards recommended do not, however, materially affect the practice of teaching hospitals and other hospitals of the more progressive kind. While participation in these grading systems is voluntary, such systems tend to exert a moral pressure which almost makes participation in them compulsory; nevertheless complaints of the impairment of the hospital's freedom are seldom heard. The movement for standardization is intensified by the promulgation by various state authorities of standards of construction, of accounting, of nurse training and of administrative procedure, and by a strong movement for the grading of all schools of nursing and the elimination of superfluous schools.

VII. Public agitation focuses the attention of hospitals on the unsatisfied needs of middle class patients for whom neither expensive private rooms nor free or part-free ward accommodations are suitable. Hospitals perceive more clearly their responsibility to the community as a whole. Semi-private service expands. Further attempts to lessen the pressure of the cost of illness on middle class families are made in the form of (a) pay treatment clinics which accept inclusive fees covering modest professional as well as administrative costs; (b) diagnostic clinics which offer costly comprehensive examinations for moderate fixed fees; (c) middle class hospital service with restricted inclusive fees and group nursing plans; (d) plans for the deferred payment of hospital charges; (e) hospital insurance administered either by commercial agencies on a profit basis or by the hospitals themselves, acting individually or in neighborhood groups. The economic factors in medical treatment are exhaustively studied by the Committee on the Costs of Medical Care, and the interest of hospitals, doctors and the general public in plans for the "group purchase" of hospital care is thereby stimulated.

Preventive Measures Are Used Increasingly

VIII. The conception of "community relations" becomes dominant in hospital administration. The hospital no longer prides itself on being a hotel for the sick but with growing ambition accepts the rôle of a community health center. Its aim is to utilize its incomparable facilities in every practicable and appropriate way for the service of the community. Staff members are invited to establish their private offices in the hospital proper (or in a connecting office building) as a means of facilitating group practice, reducing office overhead and lowering the cost of essential diagnostic service to the community. Affiliations are effected with local health departments for the conduct of clinics primarily concerned with the prevention of disease, such as venereal disease clinics, tuberculosis clinics, baby health stations, prenatal clinics. The improvement of facilities for the practice of obstetrics and of other clinical specialties in general hospitals tends to arrest the creation of small specialized hospitals devoted to the treatment of acute diseases. This movement does not, however, affect the development of orthopedic hospitals, tuberculosis hospitals or hospitals for the mentally ill, whose patients require long periods of treatment and a distinctive regime. Increased knowledge of the processes by which contagious diseases are spread makes the old-fashioned pesthouse superfluous, and departments for the treatment of communicable diseases are with increasing frequency incorporated in general hospitals. Prophylactic measures such as antityphoid inoculation and immunization against diphtheria are employed for the benefit of hospital nurses.

Full-Fledged Health Centers Appear

The mental hygiene movement claims the attention of physicians and the public, and the mental health clinic makes its appearance in the general out-patient department. The importance of dietetics in daily life is more widely recognized, and classes are organized for the instruction of groups of adult patients and of the mothers of undernourished children in the application of dietary principles. The periodic health appraisal becomes an accepted hospital function in theory if not in practice. The hospital's laboratory and diagnostic facilities, offering a range and quality of technical service beyond the ability of the ordinary practitioner, are placed at the disposal of physicians who are without staff appointments. Brief courses of instruction in newer clinical and laboratory procedures are offered to unattached medical practitioners as a contribution to the public welfare. In a locality in which hay fever abounds, a hospital provides lodgings to susceptible individuals in rooms supplied with filtered air. Clinical experience reveals the common neglect of mouth hygiene; and since the community fails to provide adequate clinics for oral prophylaxis and dental treatment, the hospital gradually expands its dental service to meet an obvious community need. The hospital sets forth its purposes and program in new monthly bulletins, which supplement the conventional annual report, and which are circulated widely. Every year some new gap in the community's health program is laid bare, and the organization of the hospital is modified accordingly. The more progressive hospitals begin to function as full-fledged health centers.

Courtesy of the Architectural Forum

New York's newest medical center, the New York Hospital-Cornell Medical Center, is a $30,000,000 plant. The first unit to be opened, a twenty-seven story building, is shown above. There will be eleven buildings in the group when the center is completed, bringing together the New York Hospital, the Lying-in Hospital, the Manhattan Maternity Hospital and Dispensary and the faculty and student units of the Cornell Medical College.

More and More Patients Seek Clinics, Study Shows

By MARGARET LOVELL PLUMLEY
Chicago

THE amazing growth of clinics in the United States in the last thirty years is clearly indicated when it is realized that there were less than 150 in 1900 and that now there are well over 7,000.

What are the factors that have caused this tremendous growth?

To consider the question intelligently it is necessary to differentiate between the two types of clinic service that have developed—the curative type, of which the out-patient departments of hospitals represent by far the greatest number, and the preventive or public health type, made up of the great majority of the independent clinics. These two clinic developments have been established for different reasons.

The earliest motive for the establishment of clinics was to give charity to the very poor. A second factor that influenced the growth of out-patient service was the establishment of out-patient departments and clinics by teaching hospitals and medical schools in order to provide their students with an opportunity to see patients in the ambulatory stages of disease.

The rapidly increasing complexity of medical practice and the rise of specialism have been other reasons for the establishment of out-patient departments.

Why People Resort to Clinics

The reasons that have led people to use out-patient departments have been equally varied. One has been the necessarily great increase in the cost of medical care. In places where clinics exist the man with more than a minor illness or requiring the services of a specialist may have to seek care at a clinic. Studies have shown that most people turn to the clinic only when their funds are exhausted or when they have been unable to obtain satisfactory care at a price they feel able to pay.

Since 1929 another factor, widespread unemployment, has resulted in a tremendous increase in the number of those seeking clinic care. Families who in more prosperous times always went to a physician when ill, are unable to pay for private care when savings have been depleted and the head of the family seeks vainly for work. Attendance at all clinics and out-patient departments has increased to such an extent that the numbers have become a great burden and those in authority are hard pressed to know how to take care of all those seeking admittance.

Although space will not permit of much discussion of independent clinics, the significance of their development cannot be overlooked in considering the reasons for clinic growth. They have been started, usually, to give the public a type of service not available in out-patient departments and curative clinics or available only to a slight extent.

TABLE I—CLINICS IN THE UNITED STATES

Out-Patient Departments of Hospitals	2,042
Independent (unattached) Clinics (exclusive of Group and Industrial)	4,535
Known Total	6,577
Group Clinics (estimated)	150
Industrial Clinics (estimated)	1,000
Estimated Total	7,727

The work of the National Tuberculosis Association and of its state and local branches was undoubtedly responsible for the establishment of the majority of the tuberculosis clinics. The venereal disease division of the United States Public Health Service and the influence of social hygiene associations throughout the country must account for the opening of many venereal disease clinics, while to the National Committee for Mental Hygiene must be given a great share of credit for the establishment of those for mental hygiene and child guidance. Official and voluntary public health organizations, public health nursing associations, social welfare organizations and clubs have developed the maternity and child welfare services, which make up the greater part of independent clinic work. Table II brings out the extent of this service.

It is not surprising, when all these factors are considered, that the number of clinics has so strik-

ingly increased, and the number of visits to them has become so impressively large. But it is surely a fact worthy of considerable study, that so large a share of the population has come to be treated for ambulatory illness through an organized medical service rather than by individual physicians. That so large a percentage of the population should, during the recent period of prosperity, have sought medical care for which in most cases only a fraction of the cost was paid is equally significant.

The figure for clinics in 1931 was obtained through a study[1] made under the auspices of the Julius Rosenwald Fund. The total, as Table I indicates, includes out-patient departments of hospitals as well as independent clinics (clinics not connected with hospitals). Private group clinics and industrial clinics, which properly belong under the independent clinics' division are shown separately since the figures given for them are estimates only. The statistics from which the total number of clinics was derived were not ready at hand but had to be collected laboriously.

TABLE II—NUMBER OF CLINIC VISITS REPORTED

	Number of Clinics			*Number of Visits to 3,456 Clinics*			*Per Cent Reporting Visits*		
Location	*Total*	*O.P.D*	*Indep.*	*Total*	*O.P.D.*	*Indep.*	*Total*	*O.P.D.*	*Indep.*
New England	728	228	500	2,526,417	2,095,072	431,345	47	66	38
Middle Atlantic	2111	564	1547	14,109,174	11,008,028	3,101,146	56	76	49
South Atlantic	498	224	274	1,428,485	1,051,795	376,690	47	65	33
North Central	1401	322	1079	5,052,166	3,421,072	1,631,094	61	68	58
South Central	627	251	376	2,825,438	1,943,662	881,776	49	58	43
Northwest Central	423	179	244	1,713,106	1,207,158	505,948	38	54	26
Far West	789	274	515	3,781,141	2,704,595	1,076,546	43	70	29
Total	6,577	2,042	4,535	31,435,927	23,431,382	8,004,545	52	67	45

Millions of Visits Recorded

The out-patient department figures were accessible and are probably the most accurate, as they were compiled from statistics secured annually by the American Medical Association. For clinics not associated with hospitals a net had to be cast widely. Of this group, published reports were available only for mental and dental clinics, the Veterans' Bureau and the United States Public Health Service clinics.

To assemble the statistics of the other independent clinics, it was necessary first to obtain a list of national and local organizations maintaining clinics and to verify the existence of clinics themselves when a record of the names and addresses of these was available. In the process of compiling the statistics, questionnaires were sent to nearly 5,000 different agencies and individuals by the American Public Health Association, which cooperated by sponsoring the inquiries. In spite of the care exercised there is undoubtedly a certain amount of duplication in the data gathered, and with equal assurance it may be said that there are in existence many clinics that were not reached. But it is surely safe to say that there are not less than 7,000 clinics in the United States, that the true figure is probably nearer 8,000 and that it may be even larger.

But clinics are not important merely because there are so many of them. It is rather the extent of the service, that is, the number of persons who are taken care of in out-patient departments of hospitals and in independent clinics, which makes clinic service of significance. The volume of work done by an out-patient department or clinic may best be measured by the total number of visits made by patients to its different departments during the course of a year. In the same way the number of visits made to all the clinics in the country will provide an index of the extent of their service. Visits instead of patients have been utilized because previous investigations have made it evident that the number of visits reported by out-patient departments and clinics is much more accurate than the number of patients. Almost all institutions keep current records of visits, usually by departments, and have been doing so for years. The sum total of the department visits is the total number of visits made to that institution in a given year.

From 36 to 45 million visits is estimated as the number of visits made to out-patient departments and clinics in the United States during 1931. The number may even be as high as 50 million. This estimate was reached by taking the total of all the visits actually reported and adding to it an estimated total for the visits made to the clinics that did not report. Over 30,000,000 visits were reported as made to 3,456 clinics, as Table II

[1] Plumley, Margaret Lovell, Growth of Clinics in the United States, Julius Rosenwald Fund, Chicago, 1932.

brings out. The number reporting was, however, only 52 per cent of the total number of clinics known to exist. No figures were obtained from the mental and dental clinics, from school and traveling clinics, or from the United States Public Health and the Veterans' Bureau clinics. Consequently the figure of 36 million is much lower than the actual number of visits that must have been made. It is estimated that at least 25 million and possibly as many as 30 million visits were made to out-patient departments, while at least 11 million and possibly as many as 15 million visits were made to independent clinics. These figures make the total of 36 to 45 million visits. No attempt has been made to estimate the number of visits to the group and industrial clinics.

Out-Patient Departments Have Increased

Although no accurate figures as to the number of patients treated at clinics are obtainable, it is possible to compute a total from the estimated total for visits. On the average, patients made from three to five visits to a clinic during the course of a year. The total number of patients who attended clinics may, on this basis, be estimated as from 7 to 11 million.

While the number of out-patient departments of hospitals is less than a third of the total number of clinics in the country, it is evident that they carry on the bulk of the service. The greater part of the service of out-patient departments is curative, that is, it is concerned with the treatment of ambulatory sick persons. On the other hand, 95 per cent of the 4,535 independent clinics were established with a public health aim and maintain, for the most part, public health or preventive services. The work of the independent clinics, therefore, may be considered as supplementary to that of the out-patient departments and represents an extremely important development in public health.

This article will confine itself mainly to the growth and development of out-patient service. Early statistics as to the number of hospitals with out-patient service are not available. In 1916 Davis and Warner, in their book, "Dispensaries,"[1] estimated that there were 645. The study of "dispensary" service made in 1921 by the American Medical Association, mentioned earlier,[2] did not separate out-patient departments from independent clinics. It is probable, however, that in 1921 there were not more than 1,000 to 1,200. In 1926, according to Michael M. Davis,[3] there were 1,790. In 1931, according to the statistics presented by the American Medical Association,[4] the number was 2,042.

Table III lists the number of hospitals with out-patient departments according to sections of the country. Nearly 40 per cent of the hospitals with out-patient departments are situated in New England and the Middle Atlantic states. Nearly half of them are in the eight states of New York, Pennsylvania, Massachusetts, California, Illinois, New Jersey, Michigan and Ohio. The largest number, 230, is in the other 40 states and the District of Columbia, from 69 each in North Carolina and Texas, to 4 in Nevada. The states included under each group are: New England—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont; Middle Atlantic—Delaware, District of Columbia, Maryland, New Jersey, New York and Pennsylvania; South Atlan-

TABLE III—OUT-PATIENT SERVICE IN THE UNITED STATES, 1931

Location	*Number of O.P.D.'s*
New England	228
Middle Atlantic	564
South Atlantic	224
North Central	322
South Central	251
Northwest Central	179
Far West	274
Total	2,042

TABLE IV—VISITS TO OUT-PATIENT DEPARTMENTS IN THE UNITED STATES, 1927 AND 1931

Location	*No. of O. P. D.'s*		*No. of Visits*	
	1927	*1931*	*1927*	*1931*
New England	198	228	1,336,854	2,095,072
Middle Atlantic	577	564	7,098,848	11,008,028
South Atlantic	214	224	714,994	1,051,795
North Central	334	322	2,033,227	3,421,072
South Central	273	251	817,404	1,943,662
Northwest Central	216	179	793,122	1,207,158
Far West	318	274	1,010,117	2,704,595
Total	2,130	2,042	13,804,566	23,431,382

[1] Davis, Michael M., and Warner, Andrew R., Dispensaries, Their Management and Development, The Macmillan Company, New York City, 1918, p. 36.

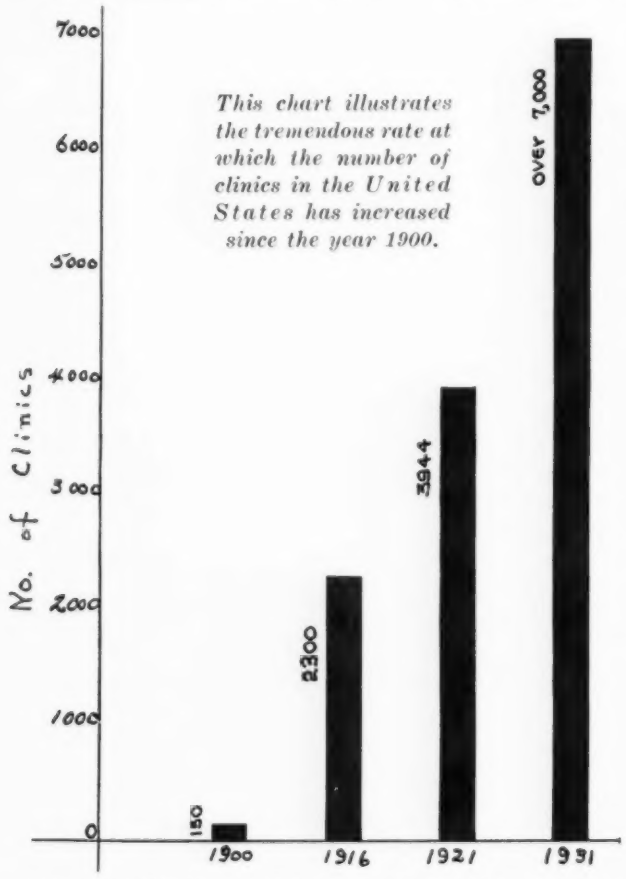
[2] Dispensary Service in the United States, reprinted with additions from the hospital number of the Journal of the American Medical Association, August 5, 1922, pp. 464 to 478, and October 21, 1921, pp. 1,447 and 1,448.

[3] Davis, Michael M., Clinics, Hospitals and Health Centers, Harper and Brothers, New York City, 1927, p. 38.

[4] Journal of the American Medical Association, June 11, 1932, p. 2,074.

tic—Florida, Georgia, North Carolina, South Carolina, Virginia and West Virginia; North Central—Illinois, Indiana, Michigan, Ohio and Wisconsin; South Central—Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee and Texas; Northwest Central—Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota; Far West—Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming.

It is to be expected that there would be many hospitals with out-patient departments in New York, Pennsylvania, Massachusetts, New Jersey and Illinois, because these are states in which are situated the largest cities in the country with big industrial populations. Out-patient departments have been largely an urban development. In Massachusetts, Pennsylvania and New York are also to be found some of the oldest hospitals in the country, institutions which were established in the period when hospitals were primarily charitable institutions and which have a long history of charitable service. But it is rather surprising to find California in the first eight. However, California is a state in which hospital and clinic service has grown remarkably in recent years.



This chart illustrates the tremendous rate at which the number of clinics in the United States has increased since the year 1900.

It is equally interesting to discover so many hospitals with out-patient departments in North Carolina, more than twice as many as in any of the other South Atlantic and South Central states except Texas. The work of the Duke Endowment in the aid of nonprofit hospitals has undoubtedly contributed to a large extent to the number in existence. Other differences in location are not so striking. The smallest number of hospitals with out-patient service are in the Northwest Central states, a condition to be expected since these are the agricultural states, with few cities of any size and with most of their population away from urban centers.

General Hospitals Lead

The federal government does not provide hospital and clinic care for the public at large. It has established hospitals only for special groups, such as the Indians, war veterans, soldiers and sailors and occupants of federal prisons. Of the 179 out-patient departments in federal hospitals, over half are in the South Central, Northwest Central and Far West sections of the country.

The majority of the 194 out-patient departments of state hospitals are attached to institutions for tuberculosis or mental diseases, although certain hospitals established in connection with the medical schools of state universities have large out-patient departments. Of the 297 hospitals under local control (county, city or both), more than half are found in the North Central and South Atlantic states and in one or two states in the Far West. Twenty-six per cent of the hospitals with out-patient departments in the North Central states are under local control, as are 16 per cent of those in the Far West and 15 per cent of those in the South Atlantic states, as compared with 10 to 12 per cent in the other sections. Fifty-six per cent of the hospitals in Wisconsin are under local governmental control.

How does this compare with the control of all hospitals in the country? Of 6,613 hospitals in the United States in 1931, 73 per cent were under nongovernmental auspices and 27 per cent under governmental. There were out-patient departments in 29 per cent of the nongovernmental hospitals and in 31 per cent of the governmental institutions. Forty-one per cent of the out-patient departments reported were in hospitals of 100 beds and over, and of this group of 841 institutions, 768 were in the New England and the Middle Atlantic states. That is to say, over a third of the out-patient departments in hospitals of over 100 beds were in these two sections of the country.

Over 70 per cent, 1,464, of the out-patient departments are in general hospitals. This large proportion is to be expected, since almost two-thirds of all the hospitals in the country are general. Out-patient departments of general hos-

TABLE V—VISITS TO GENERAL OUT-PATIENT DEPARTMENTS IN THE 25 LARGEST CITIES IN THE UNITED STATES

	No. of Visits		No. of O. P. D.'s	
	1921	1931	1921	1931
New York City	2,334,060	4,268,426	62	81
Chicago	302,924	877,486	24	39
Philadelphia	1,089,746	1,774,503	44	43
Detroit	168,568	759,728	8	20
Los Angeles	60,229	455,301	2	7
Cleveland	279,665	469,735	10	13
St. Louis	415,105	533,957	9	16
Baltimore	289,871	525,776	15	17
Boston	769,231	1,307,317	18	15[1]
Pittsburgh	118,371	297,509	13	17
San Francisco	244,023	659,463	10	15
Buffalo, N. Y.	197,323	361,883	2	11
Milwaukee	65,759	181,896	6	10
Washington, D. C.	60,700	128,458	10	13
Minneapolis	102,060	139,071	3	5
New Orleans	218,287	446,847	6	7
Cincinnati	62,570	76,882	2	5
Newark, N. J.	111,654	137,376	7	8
Kansas City, Mo.	53,413	171,255	6	5
Seattle, Wash.	20,921	24,295	1	1
Indianapolis[2]	.....	.....	..	..
Rochester, N. Y.	24,967	122,937	2	5
Jersey City, N. J.	50,206	122,206	4	5
Louisville, Ky.	83,692	66,145	3	4
Portland, Ore.	1,667	34,071	1	6
Total	7,125,012	13,942,523	268	369

[1]Boston Dispensary is included as the out-patient department of the Jackson Memorial Boston Floating Hospital.
[2]Report was not given for 1921; consequently this report was omitted from 1931 figures.

pitals handle so large a proportion of the ambulatory service rendered that the other out-patient service is negligible in comparison. It is to the out-patient departments of general hospitals that most ambulatory patients go, and these departments usually have special clinics which correspond to the services rendered by the out-patient departments of the special hospitals. An exception may be noted in regard to hospitals for eye diseases, several of which have large and important out-patient departments.

An 80 Per Cent Gain in Four Years

In considering the number of visits made to out-patient departments in 1931, it may be significant to compare them with the number made in earlier years. The 1932 hospital number of the *Journal of the American Medical Association*, previously referred to, presents on page 2,074 a table comparing the patients and visits for 1927 and 1931. From this, Table IV has been adapted. The year 1927 is a useful one for comparative purposes, since it was two years before the depression. Unfortunately the number of out-patient departments that did not report was not tabulated for 1927; but the proportion would probably be about the same as for 1931.

Twenty-three and a half million visits, the approximate number reported for 1931, is nearly ten million more visits than were reported in 1927, an increase of nearly 80 per cent in four years. The Far West, which really means California, and the South Central states, shows the greatest increases. In California the number of visits was larger by 168 per cent in 1931 than in 1927 and in the South Central states, by 138 per cent. At first glance it may seem strange that the Far West should show such a tremendous increase when the number of out-patient departments has decreased from 318 to 274. But these decreases were all in the other states, not in California. The reason for the increase in visits with a decrease in the number of out-patient departments cannot be explained in the same way for the South Central states.

In the hospital number of the *Journal of the American Medical Association* for 1931[1] a table is given showing the number of general out-patient departments and the visits made to them in 1921 and in 1929 in the twenty-five largest cities of the United States. Table V has been adapted from this tabulation, giving figures for 1931 instead of

[1]Hospital Service in the United States, reprinted from the Journal of the American Medical Association, March 28, 1931, p. 1,021.

1929. General out-patient departments include out-patient departments in general, children's, maternity and industrial hospitals, as these were included in 1921. "Related institutions" were omitted in order to make the 1931 figures comparable with those for 1921. Since it was found that much better reporting was done in 1921 than in 1931, estimates, based on 1929 visits, and in some cases on 1921 visits, or on the number of patients given, multiplied by three, have been used whenever possible for hospitals which did not report in 1931. It is believed that the table as given presents a more accurate picture than would have been possible if only the visits for hospitals that reported had been used. The fact that 1929 and 1921 figures were used for these estimates means that the total figures are still conservative.

A Striking Development

It will be seen that the number of visits to out-patient departments in New York City has nearly doubled. In Chicago it has more than doubled. In Detroit the number of visits has increased by over 350 per cent. In Los Angeles the number is nearly seven times as large. Other cities show equally impressive advances. Evidently out-patient departments have grown in magnitude of service as well as in numbers.

The Cincinnati General Hospital, Cincinnati, reported no out-patient department to the American Medical Association, but since the clinic of the University of Cincinnati Medical College actually serves as the out-patient department of the hospital and has been so listed until 1932, the last available figure for visits to that clinic (taken from a report on the clinics in Cincinnati published in 1928[1]) was included in the total for Cincinnati. By this means a truer picture is presented since the visits to the university clinic were given in 1921. Louisville, Ky., is the only city in the list that shows a decrease in its out-patient service. No reason for this is apparent. The out-patient department of only one small hospital in Louisville failed to report, while the number of out-patient departments has increased by one.

From 150 clinics in 1900 to over 7,000 in 1931 is a development so striking that it may well be compared to the growth of the high school system during the same period. The increase in the last ten years, from 3,944 in 1921 to over 7,000 in 1931 is perhaps even more significant. A large share of the urban population now receives a certain portion of all care for sickness through organized medical service in the clinics rather than from individual physicians.

[1]Davis, Michael M., and McConnell, Elizabeth, Report of the Study of Clinics in Cincinnati, Community Chest and Council of Social Agencies, Cincinnati, March, 1928, p. 5.

A Hospital Contributory Scheme That Is Successful

In view of the depleted incomes of the private hospitals in England resulting from the reduced circumstances of the well-to-do classes whose contributions formerly constituted the principal source of revenue for these hospitals, many of these establishments have been compelled to devise a new plan for taking care of the working class, according to *Nosokomeion*.

The Merseyside area, which comprises Liverpool and adjacent towns, has resorted to a scheme whereby the working class inhabitants turn over a penny in the pound of their earnings to the hospitals to constitute a hospital service fund.

The 275,000 subscribers to this scheme are represented on the administrative council of the fund and on the governing boards of the different hospitals in the territory. Their subscriptions make an average total of £102,000 a year, to which is added a voluntary contribution from the employers amounting to about £25,000.

By this means the private hospitals have not only been saved from ruin but they have been able to expend £222,000 on improving and expanding their various services. This system has received the enthusiastic support of all classes in the community and appears to be meeting a general need, it is stated.

Hospitals Are Short on Pediatric Facilities

While most hospitals in this country have sufficient beds and bassinets for children, it is the exceptional general hospital that has a good pediatric service, according to Dr. Clifford G. Grulee, professor of pediatrics, Rush Medical College, Chicago. The majority of general hospitals have no pediatrician on their staffs.

Doctor Grulee is of the opinion that there are serious disadvantages in this situation. In the first place, the children in these hospitals do not receive the intelligent supervision that is necessary to protect them from conditions in hospitals peculiarly disturbing to the young patient.

Secondly, in many communities the hospital is the rallying place for physicians, where they gather and discuss their interests, medical and social. If there is no one to present the pediatric viewpoint at these gatherings, the children of the particular community are neglected.

Another handicap, according to Doctor Grulee, is the fact that nurses in these hospitals fail to receive proper training in the care of children.

The Resocializaton of the Asocial

By JOHN EISELE DAVIS, M.A.
Senior Physical Director, Veterans' Administration Hospital, Perry Point, Md.

BROADLY speaking, it may be said that procedures for the treatment of the mentally ill have reflected the predominant ideals of variant eras represented by a progression from sorcery to science. Some of the prevailing trends at different historic periods were stated by Anthony M. Turano in the April, 1930, issue of the *American Mercury*, as follows:

"The Greeks, the Egyptians and the other purblind infidels of ancient society recognized lunacy as an illness of the mind, and attempted to cure it with music, pleasant natural surroundings and similar sympathetic influences. Then came the Middle Ages, during which, we are told, the gentler virtues of Christianity were in effect. Throughout these dark centuries the explanation of insanity was through the learned lore of demonology. The prevailing method of dealing with the insane made use of such devices as exorcism, torture and the stake. A demented person was held personally responsible for his condition; the devilish possession was deemed unmistakable evidence of wickedness. So it was thought to be the duty of both magistrate and populace to combat the internal reign of Satan by chastisement from without. That this notion continued until modern times will appear from the records of the witch trials of England and of our own colonial days."

While the present century has witnessed many evolutionary methods of treatment, the present objective of rehabilitation through treatment rather than custodial care, has not as yet been completely achieved. The present century, however, is experiencing the decline of the fatalistic doctrine of the incurability of the mentally ill in the face of statistical data showing the efficacy of modern therapy. Therapy is being established upon a sound basis as the result of the modern

Patient winners of annual awards for proficiency in athletics at Veterans' Administration Hospital, Perry Point, Md. This recognition of the patients' achievements is a valuable aid in resocialization.

scientific approach which is utilizing acceptable pedagogical, educational and psychological methods in addition to those that are purely medical. The three eras of sorcery, custodial care and scientific rehabilitation are not easily separated from one another and the effects of the first two are still given expression in political machinery.

Treatment Is Receiving Emphasis

There is, however, an awakening consciousness and social awareness of the pressing problems of mental hygiene, and the public is insisting in many quarters upon an active application of sound therapeutic practice. Dr. Jesse F. Williams reminds us that "Ideas of time and place influence what people do in shipbuilding, in war, in art, in all the manifold activities that make up the life of the people concerned. Educational enterprises respond to the molding influences of the dominant ideas and 'the present aspect of education' must adjust itself to the national ideal." One may say with equal truth that the present aspect of medicine is vitally affected by the national ideal.

We are approaching an age of new and humanitarian concepts reflected in the field of psychiatry by an emphasis upon treatment. The modern system of treatment makes a fundamental distinction between subjective and objective concepts of therapy. The former method emphasizes primarily the personality of the individual and attempts to utilize a form of therapy prescribed with special reference to his capacity for intellective, volitional and perceptual adjustment. The objective ideal of therapy is an outgrowth of the fatalistic custodial care system which attempted to place treatment upon a basis of objective utilitarianism. Such a system would say, "We need men on the hospital farm. Patient John Doe appears strong and willing." Therefore John Doe was placed on the farm and put to work with the primary idea of adding to the revenue of the hospital, rather than as a result of a careful study of his whole personality made to determine the most suitable medical treatment.

Every Employee Must Help

I have observed closely for a number of years an interesting, and I feel, a sound and valuable system of therapy as introduced and practiced by Dr. Frank E. Leslie, medical officer in charge, Veterans' Administration Hospital, Perry Point, Md. Doctor Leslie's controlling idea is every patient should be treated rather than merely given custodial care. His method utilizes the modern and conventional techniques of medication and psychiatry. He views the problem of mental rehabilitation as essentially an effort toward social adjustment and accepts Bleuler's statement that "social incapacity is the only practical criterion of mental illness." The resocialization of the individual is then the function of hospitalization. Doctor Leslie does not view this as the responsibility of the psychiatrist alone but as the duty of every employee who comes in contact with the patient and also as the responsibility of the outside social group.

All hospital employees are givers of social medicine. In order to utilize the potential therapeutic effects of personnel, other than medical, a teaching course has been instituted at the Perry Point hospital to acquaint the personnel with the fundamentals of therapy and especially the mechanism of resocialization. This course emphasizes that the individual must be viewed from the standpoint of a modifiable social animal in order to understand his behavior. The following adjustments which the individual must make are (1) hospitalization; (2) problems of religion and philosophy; (3) problems of growth; (4) reality; (5) work and relaxation; (6) family; (7) sex; (8) emotions; (9) people and social customs; (10) self-expression; (11) inward drives; (12) physical world; (13) adequate and inadequate methods of adjustment.

Normal Living Is the Objective

These adjustments are viewed as necessary steps toward the improved social conditions of the individual. Even the employee who shovels coal has an important place in restoring the mentally sick. It has been said that a fundamental characteristic of normal human personality is unity, wholeness and integration. It is readily apparent that the recognition of all the workers or assistants in this restorative therapeutic process creates a valuable morale among both patients and personnel.

Numerous cases may be cited. Before the hospital adopted the practice of inducting all employees into the system of resocialization, a number of painter employees were requested to take a patient under their wing since the patient had displayed interest in their work and was desirous of showing that he could hold his own in a normal group of workers. The painters were fearful of the patient, and furthermore did not think that they were obligated to look after him. They gradually were converted to the idea of resocialization, however, and agreed to take the patient under their supervision. He improved markedly under their sympathetic and discerning attention. He became relatively free from delusions and hallucinations. When, without his consent, he was transferred to another hospital, he became unhappy and upon his urgent request was returned to his former friends who experience great satisfaction

upon realizing that their activities comprise important elements of social medicine.

It is easy to understand the emphasis that is placed upon the contacts of the patient with the nonmedical personnel of the hospital, when it is realized that the time the patient spends in the hospital for mental illness is devoted almost entirely to convalescent care. The acute stage of medication as compared with the period of convalescence in which the patient comes in daily contact with nonmedical personnel is estimated to comprise not more than 10 per cent of his total time in the hospital. It will readily be seen that these many opportunities for social adjustment offer an important field of resocialization therapy.

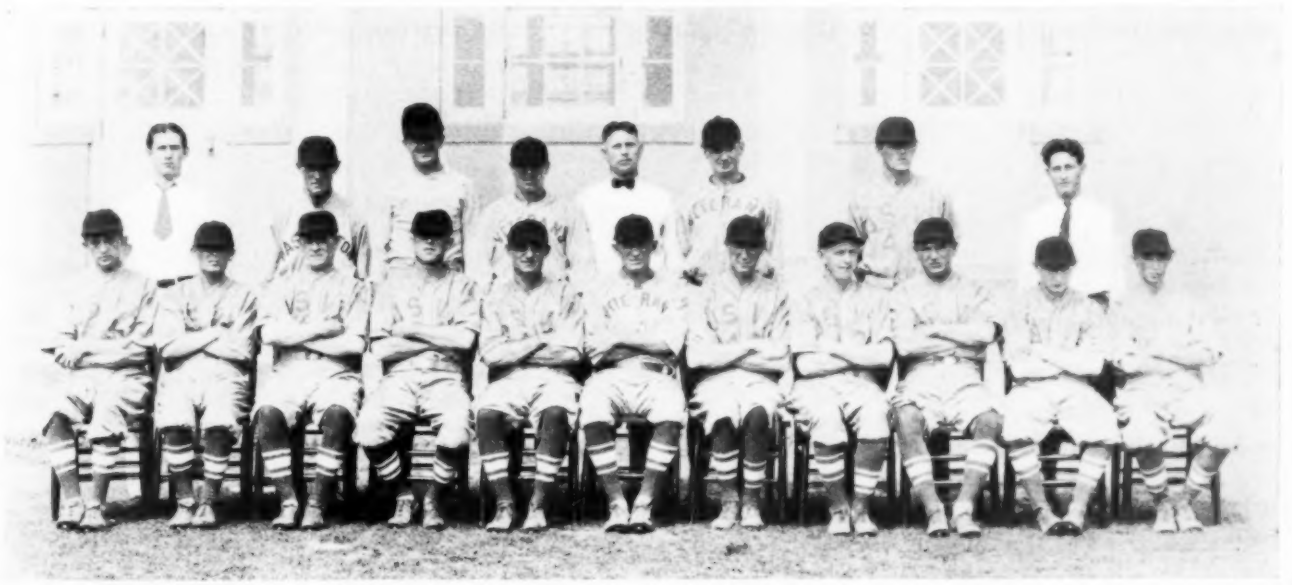
The idea has been to project into the hospital a community life containing the elements of normal and everyday conventional living. The complete and hence happy life toward which the system aims is the integrated wholesome personality resulting from an adequate and balanced ration of work, rest and recreation. All these elements of the ideal therapeutic process are to be prescribed by the psychiatrist and carried out by all the personnel from the lowest to the highest classification.

Must Help Patient to Adjust Himself Socially

If the therapist is to achieve desirable results in carrying out such a program, he must be thoroughly taught. An effective course of instruction includes a study of the personality of the individual, practicable objectives and usable methods. The objective as broadly stated is to develop the patient's capacity for improved social adjustment so that he may be able to live more satisfactorily in relation to his fellow beings. A study of the personality of the individual is approached from the standpoint of the wholesome unity which results from integrated activity. The method is broadly through resocialization.

A Grading System Is Used

An important factor of therapy, often neglected, is motivation. The actual activity of the psychotic patient is commonly accepted as an indication of his capacity. A fundamental distinction is made at Perry Point between the patient's potential capacity and the energy he actualy utilizes as well as its trends and control. The vast reservoir of potential energy must be developed through interest and incentive. John Dewey's concept of effort through interest provides the valuable educational approach. In providing adequate and suitable motivation, Doctor Leslie has instituted an interesting system of grading all mentally ill patients in relation to their improvement in social adjustment.



The patients' first team, selected from the league baseball players at Perry Point. The ideal method is to promote the players to better teams and thence to the all-star team which meets strong outside competition.

This system is patterned after the scheme outlined by Doctor Erickson and Doctor Hoskins in the July, 1931, issue of the *American Journal of Psychiatry*. Grades range from A to F and each patient is assigned a grade which is regularly posted on the bulletin board of the ward. Grade A represents the individual who is making a satisfactory adjustment at home; B represents the individual who works, plays and carries out a relatively normal routine and is about to go home, and so on down the line. The F grade represents the uncooperative, antagonistic type who will not

Convalescent patients are housed in this new building at the Veterans' Administration Hospital, Perry Point, Md.

help himself as much as his subnormal mental state and insight will allow. Under this system the patients are motivated to take clearly indicated steps which lead ultimately to "the way out." The psychoanalytic techniques, medication, occupational therapy, physical education and other resocializing and convalescent therapies all assist the patient to make the grade.

It should not be inferred from the foregoing that such a system of inducting the normal social group into the problem of resocialization will divest it of a necessary scientific character. There is always the plea of the powerfulness as well as the expediency of specialization. There is no doubt, however, but that cumulative social pressure is an effective means of bringing the antisocial into the social unity and that this potent instrument can neither be neglected nor denied in a modern hospital system that is to operate in an effective manner.

The Ideal Progression

The utilization of the mechanism of resocialization in therapy has been attacked in some quarters upon the assumption that it cannot be a scientific procedure. It is my belief that definite steps of resocialization will be discovered as parallel steps of improvement as the antisocial individual is more thoroughly subjected to social medicine.

After a decade of observation of the reaction of the psychotic patient to such resocializing procedures, I venture to suggest the following stages as representing the ideal progression: (1) unsocial or antisocial feeling; (2) social feeling; (3) social tenderness (Adler); (4) social interest; (5) social participation; (6) social responsibility; (7) relative social evaluation of others; (8) relative social evaluation of self.

These progressive steps of resocialization are not always achieved. The patient may stop at any stage. The picture is further complicated by the element of time. Ten years may elapse in a transfer from one stage to another.[1]

Some Innovations in Laboratory Design and Equipment

An interesting description of a recently completed hospital laboratory is contained in the report of the committee on hospital planning and equipment of the American Hospital Association, presented at the Detroit meeting.

A special coved corner construction of soapstone or slate laboratory tables so as to join them in a sanitary manner to tiled walls is a feature of the unit. The laboratory has a bacteriological incubator large enough to permit workers to enter it. A small room, free from air currents and equipped with a sprinkler device to eliminate dust from the air, is used for a transfer chamber in handling cultures. "Deluge" showers are provided to safeguard workers against dangers from clothing catching fire.

In the animal room the floors and sides of the animal pens are made of soapstone. There are outside runways for animals and these runways are enclosed with heavy wire mesh and with fly screens.

The receiving unit of the laboratory has pneumatic tube connection with departments for quick transmission of requests and reports, and there is a special pneumatic carrier designed for the safe dispatch from distant buildings of bottles of urine, blood counting pipettes, and other such items when quick consultation is desired.

[1]Published with the consent of the medical director, U. S. Veterans' Administration. The author, however, is solely responsible for the ideas expressed and the conclusions drawn.

When the Patient Complains What Do You Do About It?

By CHARLES H. YOUNG, M.D.

Director, Mountainside Hospital, Montclair, N. J.

TO BELIEVE all the ill heard of hospitals would be to conclude that such institutions are maintained not for the mitigation of human suffering but for the purpose of adding to the agony of mankind.

All hospitals in all communities are beset by ill reports, conceived not always in malice but often without a realization that gossip spreads, thoughtlessness exaggerates, imagination distorts and repetition magnifies. Hospital officials, medical and nursing staffs and employees are pictured as if they were chosen for their incompetence and their faithlessness to the trust imposed upon them. Reports impute to them a diabolical delight in inflicting torture and in the ungentle art of bringing discomfort to their charges.

Yet hospitals thrive and their facilities increase, because the enlightened and the just know the good that institutions do and appreciate the fact that there must always be faults where results depend upon the functioning of human brains and the work of human hands. Those who want to be fair do not advertise the weaknesses of their beloved institutions. They investigate, weigh the evidence and, if defects are found, seek the remedy.

Complaints Frequently Based on Hearsay

It is the right of a citizen to criticize, it is his duty to defend and his privilege to praise. The good citizen is proud of his philanthropies and will help them insofar as he is able, not only by giving financial support but by offering advice and praise for work well done. He often gives help by his defense when unjust criticisms and unfounded rumors start their defaming course, for he realizes that the bad repute of the hospital reflects upon him and upon his fellow citizens who founded and who are responsible for the good name and successful administration of the institution.

He knows that its sole reason for existence is the good that it can do, and that its worth can be measured only in terms of satisfactory service. His mind is not deceived or his judgment warped by hearsay evidence of poor performance. His intelligence reminds him that people make rash statements when under emotional stress, that minds become befogged in sudden troubles and new situations. He recognizes the fact that vagaries of the imagination often cloud the reason of those overwhelmed by sickness, and that the mental effects of medicinal drugs, not always apparent to the layman, cause patients to tell strange tales.

Hospital complaints come usually from those to whom hospitalization is a new experience, rarely from those who have made several visits. They come from friends of patients more often than from patients themselves and are based frequently on hearsay rather than on the actual experience of the narrator.

Are We a Bit Sensitive?

The good citizen regards his hospital as one of his best friends, ever ready to help him in time of trouble, and he will not allow other friends to malign it or prejudice him against it. He can, through interest, apathy or antagonism, help, hinder or hurt his friends, and he can give them no greater help than his kind thoughts, good will and, above all, his understanding.

Discussions concerning correct procedures in solving certain problems of hospital management have been numerous and varied, at conventions and in hospital literature. Why does the subject of complaints and criticisms evoke so little discussion? Why are there not more opinions exchanged, more plans and methods originated for defense against an antagonism which, whether based on just cause or unjust conclusions, carries with it so much potential harm?

Is it that we are a bit sensitive about revealing to others the faults attributed to us or that we wish our fellows to believe we are so superior in performance that with us flourishes of praise submerge the few weak rumblings of discontent? Are we by long sad experience hardened to the blows of blame, accepting them humbly and bearing them meekly? Do we believe there is not much to be done about it, that if people will find fault it is of no use attempting to prevent them? Do we feel that the only way for us is to keep on trying to do things in

the right way, accepting trouble when it comes and trying to live it down?

I believe that much can be accomplished through frank and full discussion of this question of hospital complaints. No set formula can be devised, no form letters adopted, no rules of procedure developed to cover all contingencies. Complaints are individual and varied, the settling of each is a problem in itself and must be separately studied and individually interpreted.

A Proud Institution

Some of us undoubtedly meet the situation better than others, some may have developed unique methods by which others could benefit. Some are worried with fear that they are not doing as well as they should and would welcome suggestions from those more experienced or more resourceful.

I therefore submit this paper for consideration and criticism hoping that it may stimulate others to pursue the subject so that I may benefit thereby.

In many situations full appreciation of the best involves sad experience of the worst. While I am by no means sure that I am handling complaints and criticisms in my own hospital in the best possible way, I am certain that one hospital I was once connected with practiced the best system of combating complaints from the standpoint of antagonism, but the worst from the standpoint of gaining good will and winning the support of the public.

This hospital was old in good service, proud in achievement, rich in tradition, secure in endowment, legacy and donation. Its trustees, of assured financial position and social prominence, took just pride in their ancestors and in the part they played in founding the hospital and in perpetuating its ideals. In brief, they maintained that the hospital could and must stand up for its rights and assume invulnerability to criticism.

Assumed an Attitude of Infallibility

Now the man who stands up for his rights may be noble but he is usually a nuisance to his fellows. The hospital that stands aloof and assumes superiority over others not only misses much that its fellow hospitals could give in cooperation, but diverts a certain amount of public interest toward others which are less unbending in their deportment.

In the hospital referred to answers to complaints of service were brief, conventional in form, stilted in phrase, any expression of sympathy or regret was veiled by a fog of assumption of infallibility. Letters to complainants were often written on the letterhead of a downtown lawyer or banker whose only acquaintance with hospital operation was limited to attendance at an occasional committee meeting or to perusal of the auditor's report. They often implied resentment or expressed a thinly veiled doubt of the complainant's integrity or intelligence.

Just Complaints Should Be Encouraged

This attitude toward public dissatisfaction is bad for two reasons, first, because it antagonizes the plaintiff, making of him a good advertiser of what he considers bad hospital practice and making of a potential friend a vindictive enemy. Second, and quite as important, it discourages others from making their complaints directly to the hospital authorities, a consummation devoutly to be wished for perhaps by a lazy, indifferent, peace loving superintendent, but a practice that is harmful to the interests of the hospital. Things happen within the hospital that are never known in the executive office until they are learned about from without and the presentation of just complaints should be encouraged. Particularly reprehensible is the discriminatory attitude taken toward the obscure citizen, who often receives scant courtesy while the high and mighty are received with deference. This indicates blindness to the advertising value of a spreading flood of praise from the maid, the chauffeur, the cook and the clerk, voluble individuals whose laudations rise as do their lamentations to the ears of those above.

A Joy to Convert Unbelievers

I confess complaining people add much to the interest of my hospital life. I like them, they bring to me the joy of combat. The evangelist saving the sinner's soul experiences no more ecstatic joy than do I in the presence of an unbeliever in the hospital who has been converted. Those who are strong in their animosity are usually emotionally intense, and they may through careful management often be converted to ardent friendship. It is worth the attempt. Look upon the process of conversion of the complainant as high adventure. Consider the thrill of facing the furious citizen, glowing in the heat of magnificent wrath, shielded by a sense of righteous indignation, hurling at you his barbed weapons of vociferous vituperation, of damning fact and puzzling fancy.

What weapons can you employ in meeting the attack? Let us assume that you are already fortified in having behind you a hospital which you know is essentially good, one that many praise and few blame. Your best weapons are the listening ear, time, attention, sympathy, understanding and above all patience. Let the grieved one exhaust his invectives and his vocabulary. Lead him to think that you believe in his sincerity and are willing to

be convinced of the justness of his complaint. Help him to get that for which he came, a chance to complain. Remember the old adage, "the higher you go the harder you fall," and subtly suggest ways of building up his grievance to larger proportions and more minute detail.

Watch for weak points in his arguments and in making your defense concede all you can without weakening your cause. Above all, pay close attention to him, let not your eyes express the wandering mind, or your fingers play with inert objects upon your desk. Remain in conference with him against all comers, and give him all your time and attention until his business is finished. Recently the telephone in my office rang while I was in conference with the president of my board of trustees. I said, "One of more importance than you demands my presence, a woman with a complaint," and he understood and released me.

The Biggest Chance for Mistakes

Suggest to your complainant the possibility of a misunderstanding of hospital relationship and environmental influences. If his grievance seems reasonable and his complaint based on fact, ask his permission to analyze the acts and conditions surrounding the fault. Never pretend infallibility, don't boast that your hospital is beyond criticism, acknowledge that mistakes are made, but lead him to realize that mistakes are made by individuals and are always in proportion to the number of individuals employed, modified by their selection, training, education and supervision. Does it appear that the great majority of mistakes arise in the nursing department? Of course, naturally. Explain why. Your hospital has, perhaps, an average of 200 patients. You have, including probationers, pupils, teachers, supervisors, general duty nurses, special nurses and others, 200 nurses; 200 individuals, 200 chances of some one individual making a mistake; the biggest group of any one class of workers is in that department and so there is the biggest chance of the mistake being made there. Half of the nurses are in the process of training, they are being trained so that they can do things without making errors.

Another Potential Source of Trouble

The next group is made up of doctors. There are about 100 of these coming in and out, busy, hard-working men, worried men, often with thoughts concentrated upon some critically ill patient, men giving their services free of all charge to many, men with someone waiting for them elsewhere, wondering how they can do everything and be fair to all and do their duty without making mistakes. Another 100 chances of someone failing to please.

Explain to your complainant that the hospital cannot be justly blamed if any one of these 300 persons, who are potential sources of trouble, makes an error. The law recognizes this when it rules that the hospital is not legally liable for their errors, when it decrees that the hospital must use due and reasonable care in their selection and that its liability ends there.

Explain Hospital's Standards

Inform your visitor that there are certain advisory and authoritative bodies who determine upon the fitness of these hospital attachés. He probably does not know that you are maintaining a school, legalized, licensed and controlled by the state board of education, that every one of its pupils has been accepted by that board, their credentials examined and passed upon, and that all details of their work, hours on duty and at study are reported to the state. The hospital has used due care and the state has so certified in its acceptance of the pupils' credentials.

Explain also that the hospital must, to maintain its position and to secure the right sort of persons for its staff, live up to certain standards, that it is subject to frequent inspection, and that the members of its professional staff must show their credentials before being appointed.

A Reflection on the Superintendent

Some complaints refer to the front door, to the admission and reception of patients. There should be few of these, for there are few individuals to commit errors, and these few are paid employees, mostly of training and experience. They are under your direct supervision and mistakes here reflect upon your selection, supervision or system. They are hard to explain away; usually they must be frankly and humbly admitted, and assurance given that the errors will not be repeated. Even in a well organized admission department misunderstandings will inevitably arise, due to overzealousness and persistence in arranging financial matters, and to insistence upon the proper respect for admission routine and visiting rules. Complaints concerning these require a detailed explanation of the difficulties encountered by these most patient and most tried of public servants, the front door people. Invite the grieved one to come on visiting day, spend an hour at the front door, and then, if he will, make suggestions for improved practice at this point.

Do you have complaints of food? Not many, if your food is good and you serve it well, but no matter how good it is there will always be an occasional patient with a capricious appetite. Sometimes you can say with truth that what the patient

desires and what you wish to give him does not agree with the doctor's orders. In the great majority of cases the complaint centers around one particular item of food or refers to some one meal. This type of complaint is not a difficult one to answer.

An Answer to Food Complaints

The hospital of 200 patients serves about 36,000 meals a month. The complainant's family, if of average size, is served at home about 360 meals per month, or one one-hundredth of the number served the hospital family. Does the lady of the house or the cook get along for a whole month without some member growling that the steak is tough or the biscuits burned or the soup badly seasoned? Is there not often something served that someone does not like? What family exists without at least one complaint a month? At this low rate, the hospital family would be entitled to a hundred, or over three every day, and if you have a properly organized and controlled food system you probably will have no more than three in a year. If ninety-nine patients seem satisfied and one complains, can the complaining one suggest how you can modify the food for the one and still please the ninety and nine?

People Are Prone to Criticize

The most frequent complaint of food, from sources outside the hospital, refers to the nurses' table. You are reputed to be "starving" your nurses, or serving them "rotten" food. If you know the rumor to be inaccurate, invite your informer, whether he is a member of the board or an outsider to appear at mealtimes unannounced and go to the nurses' dining room and partake of a meal occasionally. Make him prove or disprove his statement to his own satisfaction and then ask him to cooperate in dispelling the unjust rumor. Why does the private citizen enjoy eating a meal at some restaurant occasionally? Why is he surfeited with gustatory delight when he dines at a friend's house although the food is no better than that served at his home? Because we all crave a change. There is always a certain sameness in food prepared by the same cook day after day, and there is inevitable monotony in unchanging environment and companionship, no matter how pleasant the room or how charming the companions. No hospital escapes criticism of the food service among its residents, and this criticism repeated outside the hospital brings disrepute which it is worth while for the hospital superintendent to take time and trouble to refute.

In an analysis of complaints received over a three-year period I find nearly all are covered in those mentioned, that is, those referable to doctors, nurses, food, service and reception of patients. There are a few general complaints covering everything inside and outside the hospital, and there are some complaints that are related to minor events and individuals.

In nearly all cases there is evident lack of understanding of hospitals and individual relationships, and exaggeration of the relative importance of events. In contact with unexpected experience outside our established routine of living, we all form opinions at variance with facts. We are prone to criticize the other fellow's actions, methods and results, without study, often without the opportunity or ability, sometimes without the desire, properly to investigate and weigh the evidence.

Don't Sacrifice Hospital's Dignity

We of the hospital world know more about hospital business than do those outside. We should grasp every opportunity of selling the hospital idea to the public, and we should never shirk the duty and responsibility of meeting dissatisfaction face to face and fighting it with every weapon in our power.

I can offer no advice or consolation to the hospital that is badly organized, indifferently staffed, poorly equipped, and that has an uninterested or inharmonious board of trustees. Such an institution possesses no weapons with which to fight its enemies.

I have mentioned the independent antagonistic attitude toward complaints. In closing I should like to mention the servile and apologetic attitude, which seems in more common use and which brings a hospital into almost as much disrepute. The importance, the dignity of the hospital as a splendid service to the community is recognized by many. It must not be sacrificed to feed the emotions of the few who blame. It can be maintained, and detractors can be answered without arrogance and without undue humility.

Good Will Is Valuable

Can our time and thought be better expended than in exchanging ideas upon the neglected subject of handling complaints and criticisms? We need to know the best ways and means of defense against our calumniators. We cannot manage without good repute. Our thoughts are now more than ever before concentrated upon income, upon methods of holding it at the proper level. Is not building up good will the best method of modifying the decrease of income? Should we not consider appreciation as income and blame as expense? It takes only a little of the latter to throw the other out of balance.

A Hospital Designed to Meet the Needs of a Small Town

By EDWARD J. PETERS
Architect, Shawnee, Okla.

A SMALL hospital that can rightfully be proud of the completeness of its facilities was recently completed at Alva, Okla., a town of 6,000 population in the northwestern section of the state. The Alva Municipal Hospital was built at a total cost of $50,000, including the building site, the cost of the building and the furnishings and equipment.

The architect was engaged by the municipal authorities in advance of the usual preliminary construction surveys in order to gain the advantage of his counsel in meeting the many preconstruction problems that are bound to arise in the planning of a building, such as the selection of a site for the structure.

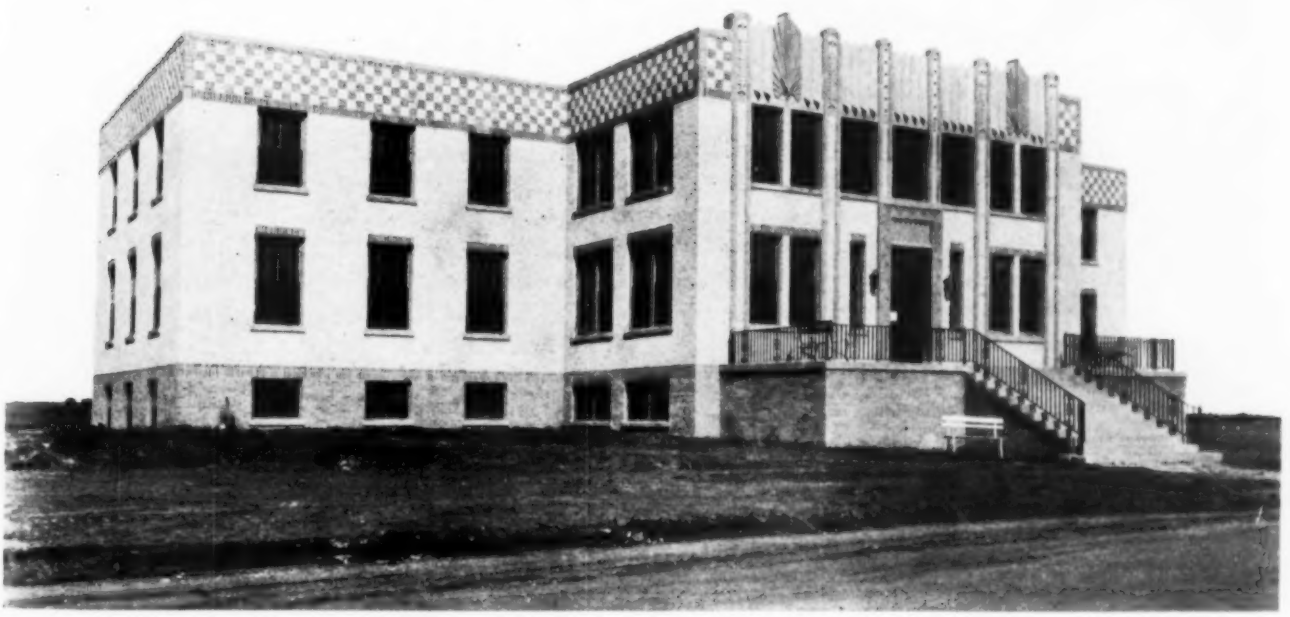
The completed building is three stories high, of fireproof construction. It has a capacity of approximately thirty beds, and the service and administration facilities of the institution are commensurate with this bed capacity.

The exterior walls of the building are of solid masonry, faced with light, cream-colored brick. Light gray brick is used for accentuation of the design. The interior framing is of reenforced concrete post, beam and slab construction. The interior partitions are of clay and gypsum tile. The tile walls of the delivery room are of double thickness, and there is a one-inch insulating membrane between the two layers of tile.

Color Is Used in Rooms and Wards

A manufactured colored stone was used for the sills, the coping and the ornamental, modernistic treatment of the central bay. The stone is tinted to match the cream-colored and the light gray brick.

A terrazzo finish is used on the floors in the corridors, the toilet rooms, the bathrooms, the dining room on the service floor, the waiting room, the administration office, the operating section and on the ramps. Terrazzo base and borders are used in all places where there are terrazzo floors. Painted



This front view of the new Alva Municipal Hospital shows the modernistic treatment of the central bay and the manner in which colored stone was used for decorative purposes.

cement floors are used in the other sections of the building.

The walls and ceilings are plastered. A semi-gloss paint is used on the walls and a flat paint on the ceilings. The wall tints in the patients' rooms and in the wards harmonize with the room furniture and fittings. Green, rose and buff are the base colors.

Mechanical System Is Complete

The door openings have steel bucks and frames. The doors are made of birch and are mahogany stained. The frames and the trim are enameled green.

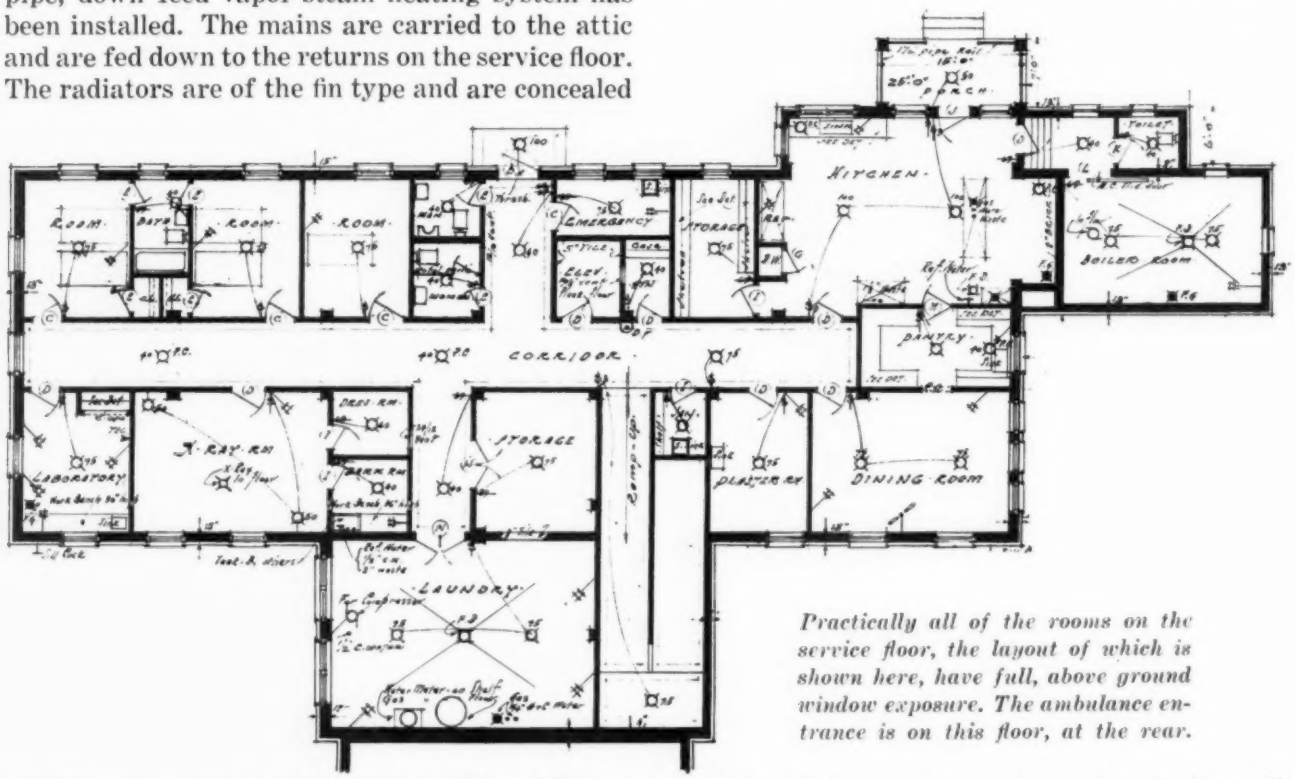
The mechanical equipment is excellent. A two-pipe, down feed vapor-steam heating system has been installed. The mains are carried to the attic and are fed down to the returns on the service floor. The radiators are of the fin type and are concealed in wall recesses under the windows. The radiator faces are finished in green enamel to match the door trim. Natural gas is used for fuel and the heating system is equipped with automatic controls. Hot water is supplied from a 250-gallon storage tank connected to an automatic, gas heater in the boiler room.

Water is supplied through a three-inch feed from the city mains. The heating boiler and the sterilizing apparatus, however, use rain water supplied from a cistern on the premises. The water supply for each floor is controlled by a valve in the boiler room, and any floor may be temporarily cut off without interrupting the water service on the other floors.

Refrigerated water is delivered from a central plant on the ground floor to the drinking fountains in the corridors, the waiting room, the x-ray dark room and the kitchen. The diet kitchens are equipped with automatic refrigeration.

The plumbing fixtures, with the exception of the slop sinks, are made of porcelain, and the fittings are chromium. The utility rooms have combination clinic (foot operated) hoppers. The doctors' wash-up sinks are in the passage between the operating rooms. The operating rooms are fitted with antisiphon aspirators and are also supplied with air lines from a compressor in the boiler room.

The electrical layout consists of a lighting system, power for the various machines, such as the x-ray, and a nurses' call system. The private rooms and the wards are equipped with night lights, with control switches on the corridor side of the wall instead of inside the room. The nurses' call system is a silent type and operates from city current. There are signals in all the patients' rooms, in the wards, in the diet kitchens and in the nursery.

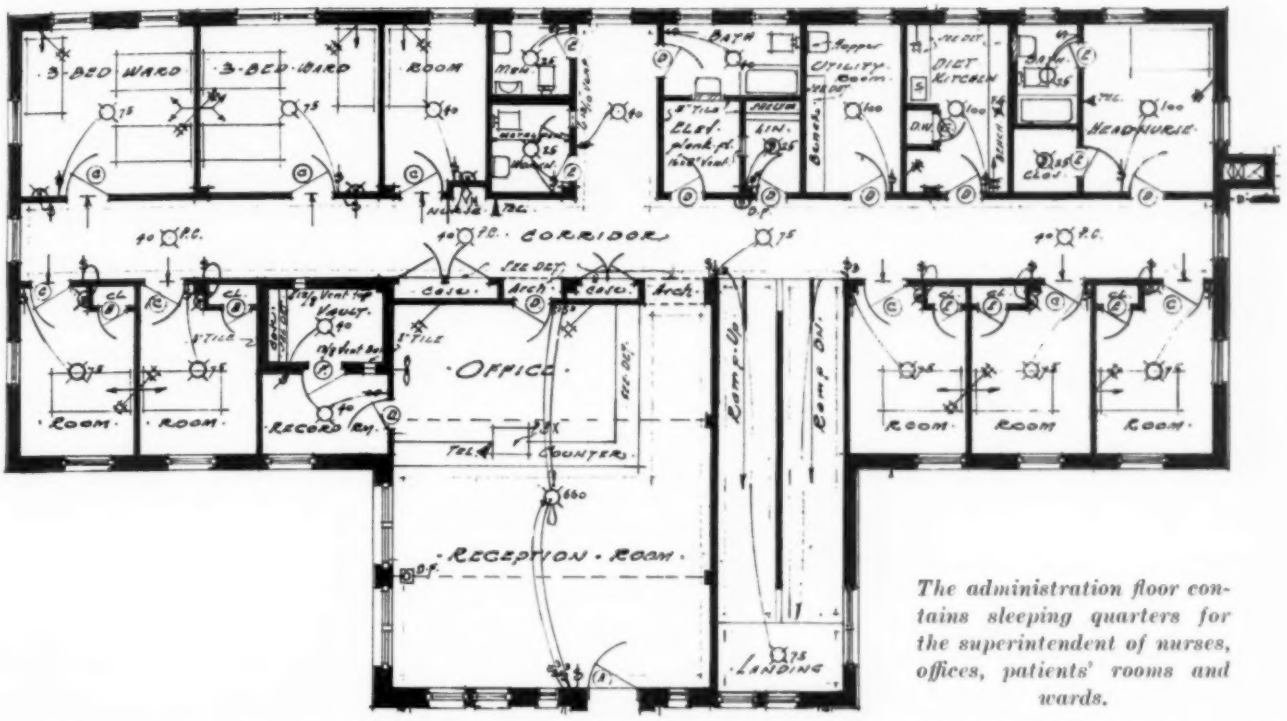


Practically all of the rooms on the service floor, the layout of which is shown here, have full, above ground window exposure. The ambulance entrance is on this floor, at the rear.

How Civic Groups Helped

The telephone trunk lines are centralized in a P.B.X. board in the office on the administration floor. There are branch telephones at the nurses' stations, in the superintendent's office, in the laboratory, in the head nurse's bedroom, in the operating section and in the kitchen. All of the branch telephones handle outside calls.

The appropriation was insufficient to permit the installation of an elevator. From the standpoint of upkeep and operating cost, also, an elevator was



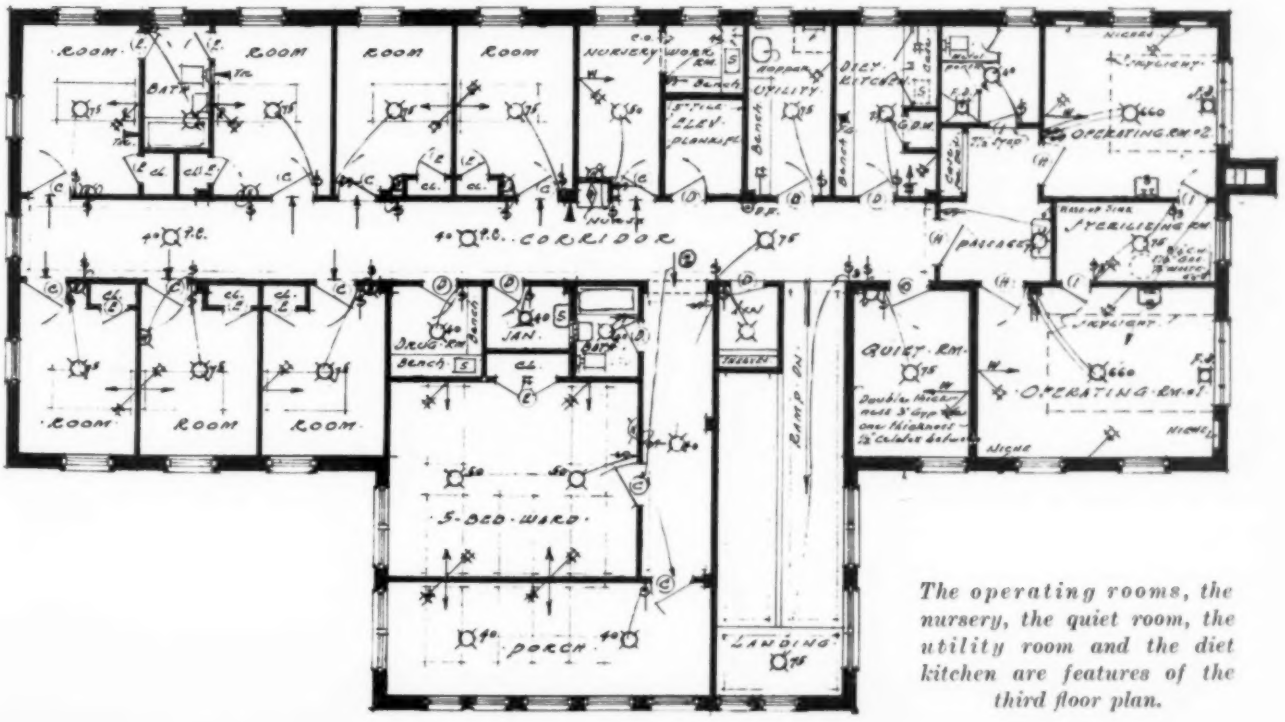
The administration floor contains sleeping quarters for the superintendent of nurses, offices, patients' rooms and wards.

considered inadvisable. Provision has been made, however, for the future installation of an elevator, the shaft having been built and the framing arranged for a penthouse. The shaft space is boarded over at the floor levels and this space is used for storage.

A ramp system is used for floor to floor access. The slope of the ramps is sixteen degrees, or less, thus providing an easy rise for all purposes. The ramp floors are designed to prevent slipping.

The plans provide for nurses' sleeping quarters in the hospital building, but it is planned to erect a nurses' cottage on the premises in the future. A bedroom with a private bath is provided on the administration floor for the superintendent of nurses. Two bedrooms with a connecting bath, each of sufficient size to accommodate twin beds, have been built on the service floor.

The contour of the building site is such that it was possible to provide a ground level ambulance entrance on the service floor, at the rear of the building. The main entrance to the building is at



The operating rooms, the nursery, the quiet room, the utility room and the diet kitchen are features of the third floor plan.

the front on the administration floor level. Practically all of the principal room spaces on the base floor have full, above ground window exposure.

The selection and purchase of equipment and furnishings was handled by a committee of local doctors. A splendid set-up of equipment was arranged for and the furnishings are excellent. Comfortable beds and mattresses, serviceable window hangings and modern x-ray, laboratory and sterilizing equipment, attest the sucess of the committee's efforts.

The patients' rooms and the wards were not decorated until the furniture had been purchased. Each room was then decorated in a color scheme to harmonize with its furniture. An attractive feature of the hospital is the air of cheerfulness that has been achieved through the liberal use of color.

Local fraternal and civic organizations assisted in paying for the furnishing and the decorating of a number of the rooms and wards. Each room or ward so handled was named for the organization making the donation. Between twelve and fourteen rooms were decorated and furnished in this manner.

Civic Hospital Employees Denied Tax Exemption

Employees of a state, county or city hospital are subject to federal income tax on their salaries, if the hospital is operated on the same basis as a private hospital, the Income Tax Unit, Bureau of Internal Revenue, has held.

Salaries of such employees are exempt when the hospital is conducted solely for the benefit of the indigent sick and paupers, the unit ruled. An authorized summary of the ruling follows:

Where a state or a political subdivision thereof conducts a hospital in such manner as to compete with the business of operating hospitals as carried on by private persons—that is, by taking all classes of patients regardless of their financial condition and requiring all patients able to do so to pay for the care and treatment received by them—the state or political subdivision will be regarded in the light of performing a proprietary function.

Where, however, a state or political subdivision conducts a hospital for the benefit of the indigent sick and paupers, it will be regarded as performing an essential governmental function. The compensation received by officers and employees of a hospital conducted by a state or a political subdivision thereof in its proprietary capacity is subject to federal income tax.

Simplicity Should Characterize the Hospital Accounting System

By R. E. HANDY
Lansing, Mich.

Modern business management presupposes the employment of thoroughgoing methods of analysis. A good accounting system used correctly is the most reliable method of acquiring good management.

A hospital's business procedure should be designed to perform two definite tasks. First, it should isolate the cost of normal operations. That is, the regular routine expenses should not be confused with the extraordinary items. Also, the cost of new construction or expenditures to increase earning power or reduce overhead should be carefully segregated from current expenses. Second, revenue and expenses should be so coordinated as to enable the superintendent to maintain constantly a sound financial policy. This requires careful analysis of all business transactions according to some systematic plan. The superintendent must know the operating costs each day.

Simplicity is essential in both of these operations. The hospital executive who is required to spend a great deal of time studying large masses of figures in order to extract a few needed facts has little time or energy left to devote to management problems. The accounting system should bring to his attention the facts that indicate the necessity for executive adjustment and control.

The Best Accounting System

Good management requires that the demand for services and the expenditures bear an established ratio to each other in every department and the accounting system should so function as to reveal promptly any deviation from the standard that may occur from time to time.

The hospital can better serve its community if it is managed in accordance with the principles that govern the successful business enterprise. The absence of profit motives in the hospital enterprise should tend to increase the incentive for sound business management.

The best accounting system for the modern hospital is one designed to indicate promptly and simply the factors that require executive adjustment and control. Blanket appropriations for operating expenses of the hospital tend to stifle business initiative. The income of a hospital should not be applied in a manner that distorts the true relationship between the earnings of the hospital and the cost of rendering the highest type of service to patients.

*The Hospital and the Medical Staff:**

Better Cooperation Between Medical Staff and Superintendent

By JOSEPH C. DOANE, M.D.
Medical Director, Jewish Hospital, Philadelphia.

IT HAS been stated on many previous occasions that staff members determine in a large measure the reputation and effectiveness of the hospital in its community. Because in the past certain intramural difficulties have at times arisen in bringing about a proper adjustment between staff members and others of the hospital personnel, particularly the superintendent, the doctor is often deliberately discouraged from taking any interest in administrative matters.

This fact, however, detracts not one whit from the truth of the above statement. The influence of the physician on almost every angle of the functioning of the hospital cannot be denied. Moreover, the effect of his presence in the institution does not end with his professional work at the bedside. Those members of the visiting staff who are content to follow a routine, who are willing to accept inferior service from nurses and others, are from the standpoint of some superintendents at least most easily handled. It is this type of physician who produces little friction and who hence least sharpens the weapons of the institution in its contest with disease. Healthy friction and an aggressive prosecution of effective institutional medicine are not always harmful qualities. It is only when ends other than those most necessary to the patient's good are sought, when personalities enter, that lasting harm is done to the hospital. So it is that the placid, easily pleased physician is not always the most useful member of the staff.

Those Who Use the Hospital

Many types of doctors are seen in the hospital's halls, wards and rooms. There are those who practice but seldom in the institution. The members of the courtesy staff largely comprise this group. The community physician who enjoys some minor hospital connection in dispensary or even on ward service is more likely to direct his patient toward a hospital bed than are the members of the courtesy staff. He has learned the ways of hospital medicine and appreciates the great advantages that have been thus placed at his disposal. He is likely to feel much more at home in institutional work than do the members of the former group and is inclined to recommend the patient for hospital admission even when no actual emergency exists. There are those who hold major positions on the hospital roster or who act as associates or assistants to the visiting chief. Surgeons, internists and other specialists comprise this class.

Doctors Don't Mean to Break Rules

Let us glance for a moment at the usual attitude displayed toward institutional practice by the various members of these groups. The physicians of the courtesy staff, because of their training and because they practice largely home medicine are prone to display an attitude of subserviency and to be in a large measure ignorant of hospital rules and the details of hospital organization. The facilities the institution offers them are so far superior to those to which they have been accustomed that rarely are complaints originated by members of this group. By the same token, they are likely to practice institutional medicine with less positiveness than the members of the regular staff. Rules when broken represent infractions due to lack of knowledge rather than to any desire to force upon the hospital the opinion of an individual.

The instruction of the courtesy staff in the ways of hospital medicine, however, is not easy because of the scattered nature of this group geographically and because of the infrequency with which the members of the groups come in contact with the administrative officers of the hospital. In contrast, the regular staff member is inclined to display a sense of proprietorship which is at once a healthy although sometimes a deterring factor in the performance of good work. He it is who, knowing the capabilities of nurses and other members of the hospital personnel, rightfully expects and demands more because of this acquaintanceship with what the patient should receive at their hands.

There are two types of hospital organizations

*This is the first of a series of discussions for the purpose of ensuring better team work in the hospital through a better understanding of the interrelated problems of the medical staff and the administration.

insofar as the relationship of a member of the visiting staff and the resident executive in authority is concerned. There is the institution blessed with a strong board of trustees, in which staff regulations and relationships have been definitely worked out and set down in print. In this type of institution the members of the staff possess but a minimum of administrative power. The engaging of nurses, anesthetists, dietitians, interns and others is performed by a board of trustees through its representatives in the hospital set-up.

Two Kinds of Institutions

At times the staff is requested and permitted to recommend the appointment of physicians to fill vacancies on the visiting roster. When such a plan is effectively developed there exists a working understanding between members of the staff and the board of trustees as to the type and amount of responsibility that visiting physicians are expected to assume. Frequently a smooth running machine, with authority properly and definitely placed and with the least amount of administrative friction, is found when such an arrangement exists.

There is a second type of institution in which the board of trustees continually displays a vacillating attitude in the making of decisions and in the application of necessary disciplinary measures. Here is frequently found a president of the hospital possessed of splendid personal traits and of a community spirit that is laudable. On the other hand, one often notes in such an institution the lack of a positive attitude when matters of policy in relation to the conduct of the hospital are being considered. If under the above circumstances a staff, strong in initiative and inclined to assume an aggressive position in protecting its so-called rights, is found, it is not unlikely that staff policies will be indefinite and that problems will be settled on the basis of individual occurrences rather than in accordance with careful and uncompromising adherence to predetermined policies.

In such an institution the superintendent is inclined to be harassed by uncertainties, to be vacillating, fearful of assuming undue authority and inclined to avoid making decisions. When the president of a hospital board displays these characteristics, his colleagues are prone to be listless, disinterested and difficult to assemble for meetings. Under these conditions the executive frequently experiences many obstacles in securing a definite decision from his superiors on matters troubling him. As a result, staff friction and lowered morale in every other hospital department are likely to exist. Specifically, inefficiency in the prosecution of routine administrative matters follows as a natural corollary.

Without strong board support, the executive fears to assume a firm stand when the purchase of expensive equipment is recommended by a staff member or when policies that he thinks are not for the hospital's good are suggested. As a result the ill-considered purchase of hospital supplies and equipment because of an individual's insistence brings about not only the waste of the community's money but also the cumbering of the hospital storeroom with equipment, later not used even by the physician who requested it.

Such a situation cannot arise in institutions where there exists a feeling of mutual respect between the staff and the board and where the acts of the executive merit and receive the support of his superiors. Unfortunately, however, board members require that their attention be repeatedly directed to the fact that in the former instance there is an absence of the high morale, efficient medical care and general satisfaction throughout the whole hospital that are so conspicuously present in the latter.

To be sure, here and there will be heard the plaint from disgruntled staff members that it is they who make the hospital possible and that in their hands has been placed the safety of the life of each patient. In addition, it is frequently called to the attention of the board that the income of the hospital would not be forthcoming were it not for the patients referred to private rooms by community doctors. There is much of truth of course in this contention, and hospital boards should assiduously avoid the manifestation of any degree of autocracy in the administration of their institutions.

The Happy Hospital

In the latter plan all policies are finally decided by the board of trustees with or without the recommendation of staff members. There is no more regrettable situation than that which exists in a hospital in which the board of trustees has surrendered to the members of the visiting staff its legal right to make decisions and to enforce policies. The staff controlled hospital is often the battleground for the most virulent controversies not only between the physician and the lay administration, but just as often between members of the visiting staff themselves.

The happy hospital is one that has adopted the midway plan in which the dignity and professional attributes of the physicians are recognized and in which the doctor in turn by his attitude toward the patient and the hospital deserves such respect.

It has been said that the influence of the staff extends to every activity in the hospital. The surgeon is the general in command of all the forces

in the operating room during the progress of surgical treatment to the patient. It is his right and his duty to issue orders to all those round about him and to require obedience thereto. On the other hand, while he schedules and performs operations and while in emergencies he lays aside routine rules for the good of the patient, he still is answerable to the managers of the institution for the observance of predetermined rules, and for requiring that others adhere thereto.

Physician Deserves Attentive Service

The physician is provided with well trained graduates in medicine, who comprise the resident staff, to assist him in performing his work. As a member of the appropriate committee of the staff he has no doubt also had not a little to say with regard to the selection of these persons. And yet, while it is his duty and his right to require the careful attention of the intern to the treatment of patients under his care, he may not assign to specific services the members of this group or refuse to accept an intern who has been allotted to him. On the other hand, in the presence of inefficiency and inattention the chief has full authority to make representations to resident hospital officers and to insist that matters of this sort be adjusted, in the best interests of the patient. And so it may be said that in matters professional, the physician or surgeon is in direct control of the activities of the intern group.

There seems to have arisen recently a somewhat different attitude from that which formerly existed on the part of the physician in regard to the hospital training school. Here and there may be observed an interested but not completely informed physician insisting that the curriculum of the school be altered in some major or minor respect. The visiting physician of course is interested in having at his command well trained nurses, whether they be pupil or graduate. He is of course concerned with the type of training they receive during their stay in the hospital. But he is not usually capable of judging the educational correctness of a curriculum or the proper arrangement of its subjects. He occupies the same position in regard to the nurse as to the intern insofar as adherence to hospital rules is concerned.

Of course the physician rightfully demands obedience to orders and requires that the treatment he has suggested be carried out by the nurse. He may not, however, with justice insist that an individual nurse be removed and another placed in her stead because of his belief that she is inefficient or discourteous. These instructions must emanate from the directress of the school. He may rightfully insist that he be given attentive service, but it is not within the bounds of reason to expect that the physician should be permitted to designate the individual from whom such service should come. The physician, not without cause, resents the reporting by members of the nursing group of infections or of infractions of rules by chiefs. Frequently, however, had he assumed his rightful place and performed his duty, it would not be necessary for the nurse to make known such happenings to those in authority.

Often misunderstandings arise between the physician and the members of the training school because of a lack of information on the part of the former concerning hospital organization and in regard to its orderly methods of procedure. It may be said here that what is most needed by both hospital administrators and members of the visiting staff is more information by each concerning the practices and policies of the other. In the past the fact has not been fully recognized that there is a definite relationship between the duties expected of the staff and those that have hitherto been wholly assumed by the superintendent.

The executive is the purchasing agent for the institution. Yet the need for procuring much expensive equipment originates with the staff. The superintendent, having learned of such requirements, makes the necessary purchases in the most advantageous manner possible, acting on the authority transmitted to him by the trustees.

Superintendent Must Use Tact

The physician, however, in order to assume this type of duty must keep himself informed as to the modern trends in the development of scientific instruments. He should not be an automaton with hands extended which receive and put into use every tool supplied. He surely could derive great benefit from attending conventions, reading the text and advertising of hospital magazines, and studying there the newest and most effective equipment used in the treatment of the sick.

The physician should certainly not rely upon the superintendent to sell him the idea of procuring a modern instrument. Even such matters as the proper conduct of the laundry have been known to become of practical interest to the doctor. In one instance, the constructive activities of a staff physician reorganized a whole laundry system, bringing about not only a saving in money but an increase in bacteriologic cleanliness. To most members of the visiting staff, the institutional laundry is but a name. It is in no way being contended, however, that the doctor should feel himself responsible for the conduct of the laundry, dietetic or other institutional departments, and yet the patient is not likely to be as quickly re-

turned to health if the physician practices only bedside medicine and does not acquaint himself with at least the existence and the rationale of many of the other hospital activities.

Because the doctor is not fully informed concerning the expense of carrying on hospital work he is inclined to request drugs whose efficiency has not been proved and upon which have been placed almost prohibitive prices. If he is not understanding, when such chemicals are not forthcoming he is inclined to adopt an offended attitude or to criticize the officer upon whom he made the requisition. The attitude of the wise superintendent in regard to suggestions received from physicians as to purchases should not be autocratically to blue pencil the request, but to interview the physician and express an appreciation of his interest while explaining the difficulty at the present moment of supplying the article desired. To be sure, many expensive and ill-considered requests will be received for supplies, but it is possible for a tactful executive to spare the hospital unnecessary expense without offending the physician or curbing his initiative.

It is said that there are ninety thousand physicians in the United States directly or indirectly connected with hospitals. Their influence on hospital finance is enormous. They largely determine the earning policies of the hospital. They supply the clientele. They also exert a great influence upon hospital disbursements because of their influence on purchases. Let it not be lightly accepted as a truth that the physician is routinely a poor business man. This is often an ill-considered lay conclusion. Throughout this country many proprietary hospitals are being conducted by the physician in a most efficient manner. The practice of group medicine to which sound business methods must certainly be applied in order that financial success may follow is often directly under the supervision of the doctor. The physician's lack of business ability is often simply the result of his having insufficient time for business matters.

Encouraging Signs

The increasing frequency with which one observes the close association of physicians and hospital executives on the same program and the attendance of physicians and superintendents together at hospital conventions are all encouraging signs which point to the rapid disintegration of that ancient barrier that has existed between lay and professional hospital work and workers. Moreover, it is hoped that oftener in the future the physicians' current library will contain not only scientific journals in which matters pertaining to the practice of the science and art of medicine are discussed, but also magazines devoted to the advancement of his workshop—the hospital.

In the September, 1932, issue of THE MODERN HOSPITAL the psychology, organization and relationships of the visiting staff to the hospital were described in detail. But too scant has been the comment in regard to the importance of the niche the resident physician fills in the hospital scheme. To be sure, a modicum of attention is given in most institutions to his physical comforts—his food, room and laundry. He is sometimes supplied with his uniforms and less often granted an honorarium, often microscopic in proportions.

The Physician of Tomorrow

Nevertheless, the amount of medical experience that he receives is usually in inverse proportion to the size of his financial reward. His curriculum for the period of his internship is frequently sketchy and clumsily fabricated and often makes no allowance for the generally accepted fact that this young physician cannot be present in two somewhat widely separated places in the hospital at the same time. On his arrival at the institution he is rarely given a printed list of instructions as to his work and usually he first learns of the existence of a rule when he is chided for breaking it. But the hospital would find much difficulty in properly caring for its patients were the services of the intern staff not available.

In some institutions it has been found difficult to convince the visiting staff members of the advisability of organizing such a group. In these hospitals, records are sketchily compiled, dressings are likely to be tardily performed and the educational morale often remains at a low ebb. Moreover, the hospital library is most likely to be conspicuous by its absence or its lack of completeness when the interns' presence does not require that it be kept up-to-date. In every institution approved for internship access not only to current literature but to a manual of practical procedures pertaining to the intern's work is required and is of the utmost importance. It is because of this fact that most modern hospitals endeavor to compile a folio of such procedures as they are carried out in the particular institution.

Hence, in this new series it appears proper to augment the literature available to the intern by printing from time to time a description of the technical practices, a knowledge of which is necessary to the intern in performing his everyday work. There has been no intention, in penning the above comments, of lessening the importance of the members of the visiting staff to the hospital. All must agree that the intern of today will be the visiting physician of tomorrow.

Reducing the Cost of Hospital Radio Installations

By EMILY OSGOOD PEIRCE
Cambridge, Mass.

HOSPITALS that wish to install a radio system but that have only moderate means for the purpose may be interested to hear of an easy expedient for reducing to a minimum the amount of money required.

In making an estimate for the cost of a head phone installation, the contractor allows a certain proportion of the amount for apparatus to be used in overcoming certain difficulties. In a one program installation these difficulties consist of the hum and other noises from the power line and in sharp clicks and possible changes of volume as the phones are plugged in or out.

In an installation of two or more programs there is the added difficulty of leakage of programs by induction from one circuit to another. The shielded cable and coils that are generally used by contractors for the correction of this leakage alone are often expensive, in some cases costing about a third of the entire amount.

In experimenting for the four-program radio now in operation at the Cambridge Tuberculosis Hospital, Cambridge, Mass., I found a simple method of solving all these problems at once.

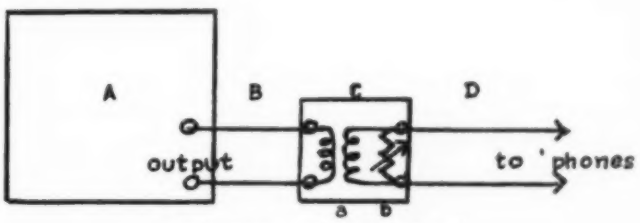
The Behavior of the Resistance

I found that a small resistance, placed in shunt position across the output of each radio set—that is, after the transformer which separated the loud speakers from the head sets—removed the hum and other disturbances coming from the power line, prevented unpleasant clicks and possible changes of volume when phones were plugged in or out (this was tested for many hundreds of phones, proving that the installation would need no attention while in operation) and eliminated cross-talk, even when the conductors happened to be in straight pairs. This last function has also been tested for steel conduit.

Prof. G. W. Pierce, Cruft Laboratory, Harvard University, throughout my experiments has grudged no time or trouble in his constant kindness and invaluable advice to me. He recommended that I should use a variable resistance of 50 ohms for, in measuring the resistance, he noticed that the amount necessary varied from 25 ohms slightly upward according to the individual radio set.

He explained the behavior of the resistance in these words:

"The function of this shunt resistance is twofold: (1) It prevents the rise of potential on a line from which all head sets have been disconnected. Such rise of potential, if permitted, would leak from the open-circuited jacks on which persons were listening and would cause interference.



A diagram of the control unit.

(2) This shunt resistance, being of low value (about 25 ohms), maintains almost constant the voltage at the receiving head sets whether one set or many sets are plugged into the circuit. This you will understand if you note that the head sets have each about 2,000 ohms resistance, so that 25 ohms shunted by 2,000 ohms remain almost 25 ohms and, if shunted by ten 2,000-ohm telephones giving equivalent parallel resistance of 200 ohms, they would change merely from an equivalent of 25 ohms to about 20 ohms."

A represents a radio set. It need not be an expensive one. The small sets which retail for about fifty dollars will give ample volume. The dealer will affix an extension jack for a small additional sum.

B represents the loudspeaker lines. Of course it will be understood that these must be properly shielded if they are to be run where they will affect the phone lines.

C represents the control unit, containing (a) the output transformer which separates the speakers from the phones and (b) the 50-ohm rheostat which removes the hum, maintains a constant volume and prevents cross-talk. The best ratio for the transformer seems to be one to one. If a two

to one ratio is preferred, one of the secondary terminals must be grounded, otherwise, there will be cross-talk in spite of the shunt resistance. To increase the ratio still further is to recall to the circuit increasingly all those noises that have been eliminated.

D represents the head phone lines.

Although, of course, both resistance and transformer can be bought separately and their connections made by a competent electrician, a control box with a dialed panel and terminals for the four necessary outside connections will be found to be neater, more convenient and more permanent. A box with these specifications can be made by any manufacturer of precision electrical apparatus for about $35 for one program; two or more programs will cost proportionately less if their control apparatus is placed in a single box.

In any radio installation it is important that the patients' outlets shall be as sturdy and foolproof as possible. These may be made with volume control, selector switch jacks, pin jacks and telephone hooks. It is a simple matter, also, to provide patients with small individual outlet boxes connected with the wall plate by a cable. This is particularly desirable for patients in a cast, or otherwise unable to turn in bed.

I wish to express my gratitude for generous advice and help from Prof. E. H. Hall, Prof. A. E. Kennelly, Prof. G. W. Pierce and Prof. F. A. Saunders of Harvard University; Mr. Carley of the Cruft Laboratory of Harvard; Mr. Downes, Mr. Tait and Mr. Gordon of the electrical staff of the maintenance department of Harvard University; Mr. Holland of the Garfield Electrical Company, and Mr. McElroy of the General Radio Company.

Though I cannot be responsible for any installation in which my system is used, I know that it is already working well in two hospitals, and I shall be very glad to answer any questions about it.

The Hospital's Part in the Crusade Against Tuberculosis

The sanatorium has played only a small part in the crusade against tuberculosis, says Dr. Georges Petit, Paris, France, whose opinions are presented in the *Journal of the American Medical Association.*

Present conceptions as to the most effective means of combating tuberculosis must be modified.

"One of the chief mistakes," says Doctor Petit, "has been the multiplication of small dispensaries, installed with the aid of private funds. The dispensary is a useless innovation. It should be attached to the hospital and managed by administrative boards. Such an attachment would assure better equipment, and there would be a greater certainty of its proper use.

"The greatest reproach that can be brought against a sanatorium is that it receives only certain classes of patients; for under these conditions, the sanatorium is not a general social factor and it loses much of its utilitarian character in the crusade against tuberculosis.

"The hospital-sanatorium is, therefore, the only institution that meets the scientific conceptions and the needs of society. The great effort to establish in the hospitals a special pavilion for the tuberculous is the beginning of a change that is widely needed and universally demanded."

How Hospital Equipment Affects the Quality of Nursing

"It is impossible to build up a good nursing service unless the hospital is well equipped to meet the demands of all services," declares Anna G. Williams, Memorial Hospital of Laramie County, Cheyenne, Wyoming, whose paper "The Quality of Nursing Service as Affected by Hospital Equipment," was read at the nurses' biennial convention, San Antonio, Tex.

"Some hospitals try to meet the situation by providing floating equipment, but this method is unsatisfactory. It lowers the efficiency of the nursing force through the loss of time and energy made necessary by continual borrowing. It also results in lack of punctuality in carrying out orders and is an excuse for the forming of bad habits as regards prompt obedience to a doctor's instructions. The same hazards result from inadequate equipment, and the same lack of efficiency."

To make possible the practice of good technique in all nursing procedures, the hospital's equipment should be uniform throughout, every unit and ward being furnished with supplies sufficient to facilitate good nursing, Miss Williams emphasizes.

Standardization of hospital equipment, while necessary for the proper care of patients and for a standard technique for nurses, brings with it a fresh problem, in Miss Williams' opinion. The resourcefulness of students can be crippled by the hospital with its multitude of devices for the care of the sick, until they are unequal to take the responsibility of handling a case away from the convenience and protection of the hospital.

Providing an Adequate Community Nursing Service

By EDNA L. FOLEY
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AN ADEQUATE community nursing service would include all varieties of skilled competent nurses, their work so coordinated that sick people in every rank of life would get good nursing care. Naturally in the foreground or the background of this picture we should place a hospital well staffed, well conducted, giving students good preparation in all of the different branches requiring skilled nursing or having a staff of well supervised able graduate nurses. Such an adequate service would so vary with every community that it is impossible to outline one scheme governing all.

As I pondered over this topic, Tolstoi's message to his friends throughout the world flashed across my mind: "That the world may become more friendly." Isn't this what all of us need to consider before we can discuss an adequate nursing service, an adequate teaching service, an adequate political set-up or anything else for the great rank and file of the public?

Nurses are apt to think themselves the only group interested in nursing, but there are other "parties of the third part" who must enter and stay in our stream of consciousness if we are going to help the nursing profession as well as attempt to give an adequate nursing service in any community. Those parties are the medical profession (to whom we are constantly indebted) and the public at large, whose interest in our work is vital as well as personal, for the public is our clientele, our moral and financial support.

Three Groups of Nurses

Sometimes nurses speak as if they were an isolated even a forgotten group. Actually, someone is always thinking of them, their work and their needs, at times with interest and an eager desire to help; again with bitterness and a certain wistful wonder that such persons should be foisted upon a long-suffering and innocent public.

In thinking of nursing service, most of us divide all nurses into three groups: those in institutions, those in private duty, those in public health. Through our professional organizations, we can all be friendly and mutually helpful, but are we? Nurses employed in any one of the three groups are apt to think that they know all the duties and privileges of the other two groups. Mentally, they may dwell more upon the privileges—the free Sundays of the public health nurse; night duty relief for the institutional nurse; open vacations and trips home for the private duty nurse. The institutional nurse thinks of the relatively short working day of the public health nurse, her free Sundays and evenings, her opportunities for recreation, for social contacts and for further study. It is true that public health nursing is apparently a field in which regular hours are given to the work and in which the salaries, until recently at least, have been paid regularly, although these salaries have never, in most places, adequately repaid the good public health nurse.

They All Have Their Troubles

The field of public health nursing is one in which publicity has done much for the worker. For the last twenty years we have constantly heard about public health and public health nursing. Sometimes I think that our publicity has made work in the public health field seem too simple and too easy. Only nurses working in it realize that the so-called eight hours are long, packed with responsibility as well as with hard work, for the mental strain of shifting rapidly from the problems of one household to those of another is terrific.

A good public health nurse cannot leave her district at night, turning her patients over to a night nurse. She carries them in her head and heart. She is planning how to get shoes for a child, how unemployed fathers may be wisely directed and encouraged. She wonders if the family of a critically ill patient has learned half its instructions about that patient's medicine and need for sleep and quiet. She is reviewing her patients to see where she can find a good neighbor who will stay with little children while their half-sick mother goes to the dispensary. None of this is asked of her in printed rules but as she leaves her district, no really good field nurse can forget her patients

just because the clock strikes 4 or 5 p.m. She is constantly thinking of their needs and devising ways and means of meeting them.

During these last few bitter years, only the gratitude of the poor, the sacrifices that they so willingly make for each other, and the backing of groups of lay people just as eager as the nurse herself to ameliorate the lot of the unfortunate, have enabled the public health nurse to carry her load.

Sometimes she rather envies institutional nurses. Their hours seem fixed and they are relieved by other nurses when they go off duty to their rooms and their meals; they are not supposed to have to think much about the work left behind them. The public health nurse forgets that the nurse working in an institution is usually working under tremendous pressure, is worried about her patients, about the amount of paper work that never seems entirely caught up, about a spread awry or one requisition blank lost. No institutional life, twenty-four hours a day, is particularly agreeable to most home loving women.

The private duty nurse perhaps views nurses in both these groups as fortunate. Her own calls are uncertain; her hours are long and personally inconvenient. Behind her is no group of trustees or attending staff to appreciate her best efforts and to help her obtain, with a minimum amount of friction, the food, rest and salary that are so essential if she is going to remain physically fit and capable of making herself acceptable to her patient and his family.

The Changing Economic Conditions

But I mentioned a moment ago two "parties of the third part." The public is the most interested party in any large business or professional undertaking. It is often the least considered. It wants an adequate service. By "adequate" it means a quality of service that will bring comfort and healing to the patient as well as relief from strain and worry to the family.

The economics of every situation appeals to us now as never before. Having spent three years in the hardest kind of work, acquiring certain skills and knowledge that promised them a fair living return, it is only natural that nurses should want to realize on that investment. But in 1930, the United States Chamber of Commerce published figures showing that 87 per cent of our total population (their future patients) were receiving incomes of $2,000 a year or less. Only 5½ per cent had incomes of $5,000 or more a year. Our changing economic world has decreased the number of people in the 5½ per cent group; it has increased the number in the 87 per cent group. This more than 87 per cent of our public can least afford to be sick; nevertheless it requires good and skilled service during illness. Here is where the community public health nurse must supplement all other kinds of nursing and yet everywhere we hear that public health nursing is being cut down, hospitals are less able to accept free patients, dispensaries are swamped, doctors and nurses are idle.

Whose Fault Is It?

Even when an income is adequate (and Mark Twain once reminded us that an adequate income was always a little more than a fellow had), it is extremely difficult for one or several nurses to satisfy every need or whim of a family. To any family, an adequate nurse must be technically perfect, socially acceptable and able to adjust herself to any household situation. This is a large order. Few experienced nurses fit well into such a program, and young graduate nurses, during the weary years when they are acquiring their experience, are left to learn by trial and error, how to meet the needs and desires of their patients. I have known nurses who have violated every canon of good taste, of good sense and of nursing education in their shocking care of patients. I have known other nurses (and this is not an exaggeration) who have filled early graves because they put both heart and soul as well as their personal strength into their work but when they became ill, there was no one to care for and protect them. Professions as well as industries have their scrapheaps.

Having touched briefly on two important elements in this large picture, let me turn to the third —the medical profession. One would suppose that physicians were naturally interested in securing good nursing care for their patients. How often do they stop to consider how time consuming and taxing good nursing care is? Whose fault is it that the doctor (whose work can be made or destroyed by the excellent or poor nursing care of the patient), knows so little about the difficulties facing nurses, student or graduate, who attempt to give that care?

All nursing groups have been negligent in not trying to explain to physicians just how long certain treatments take, how much skill is required for those treatments and how impossible it is to attain this skill if it is not founded on knowledge and if the student nurse has not been well taught, well supervised and well grounded by long practice in doing difficult things well, whereby she is helped to apply this knowledge which she gets with such difficulty.

Physicians and surgeons have failed to help us set and demand a minimum standard of good nursing. Perhaps they have been too busy keeping up

with their own professional problems but more likely we have not been candid in sharing our problems with them. My personal experience with hundreds of physicians has been that all good doctors are truly interested in seeing that their patients get the best nursing care available and that the nurses get a square deal.

Two of my friends, both women physicians, never speak of the "medical profession" and the "nursing profession." They just take for granted that medicine needs nursing quite as much as it needs doctoring and that we are complementary groups of a huge profession whose standard is good service to the public.

Water cannot rise higher than its source. The nurse who has spent three years in a hospital where a mediocre staff has tolerated mediocre nursing, will be a poor nurse all her life, although she may be a good woman. The economic problems of nurses and physicians are serious but both groups exist primarily to care for the sick and to prevent illness. Perhaps the economic problems of nurses could be solved more easily if all nurses were given an adequate practical experience in good care of sick people.

The hospital is more than an institution in which groups of workers receive some laboratory experience. From the derivation of the word, we know that it was originally intended as a friendly shelter to which the sick were welcomed and given the best skill of each succeeding generation. To most nurses a hospital is a place where they are taught the care of the sick and the reasons for that care, and to which they return later, in various capacities, to continue to give that care or to teach younger nurses to give it.

A year ago I heard a surgeon remark that the best attending staff in the world did less to make the reputation of a hospital than the quality of its nursing service. It is fine to know that he is on the executive committee of that school of nursing and a tower of strength and help to its director.

Nurses Need Better Organization

It always sounds easy for an individual to discuss another person's work but for some time it has seemed to me as if nurses should get all of their basic sciences in junior college and that they should be older when they enter schools of nursing. Sometimes we hear about the overeducated nurse. There is no such a thing as an overeducated person. There are persons, both men and women, who are educated beyond their capacity and who expect favors of life because they have waded through a textbook or secured a credit or two or possibly a degree. They are the mistakes of our educational system; they are undereducated in more ways than one. Nurses do need better organization. Both in the schools and afterwards, no matter which one of the three fields of nursing they enter, nurses should be organized under groups of lay trustees, advisory committees or whatever you please, so that the older, good nurse will be sent to those patients who need her special skill and experience, will be paid according to her ability and will not be expected to compete with the young graduate only a few days out of the hospital.

The day should come when nurses will be permitted to charge by the case rather than by the day; when their hours will be adjusted according to the patient's need as well as according to the amount of actual nursing service that is rendered.

Private or special duty nursing is misunderstood by the public because a nurse caring for one patient looks like a person who works hard for an hour or two and then has a great deal of leisure. Actually, unless that nurse is in a hospital in which she is well known and welcome, she is neither fish nor fowl, neither a member nor a friend of the family. She is someone hired to be there because the patient must have her. She is a person from whom the family hopes to get a little more than it is willing to pay for.

Must Educate Physicians and Public

This plan of special fees and adequate nursing may sound Utopian but I believe that some day very sick patients will have several nurses with them during the twenty-four hours, each nurse slipping into the vacancy of her predecessor so easily, so well informed of what has happened in the preceding few hours, that neither patient nor family will notice the change. The charges for this kind of care must be scaled according to the family's ability to pay. The first two or three days of nursing will be expensive. After that, less skilled nursing and therefore less expensive nursing will be provided. It is conceivable that public funds or insurance funds must help compensate both these types of nurses but the patients must get better care. When a patient has passed the stage when steady, twenty-four-hour-a-day nursing in a hospital system is needed, perhaps both in hospitals and in homes, by group nursing or by hourly nursing and public health nursing, some combination of all types of nursing can be provided so that all patients will get much better care and all nurses will have proper working days. Hourly nursing should be an appointment service operated by a local registry. It will come when people learn to understand the importance as well as the expense of nursing skill.

We shall get none of these things until nurses take physicians and the public into their confidence

and through interpretation of what they are trying to do for the sick, teach the members of both groups to see that a good nurse six or eight hours a day is safer than an indifferent nurse for twenty-four.

There will never be an adequate community nursing service in the sense that families can get all the nursing they want or think they want, unless they are able and willing to pay for it. It is a human trait to get as much as we can for nothing. But when physicians and nurses get together and work out these problems more sympathetically and ethically, when both groups take the public into their confidence every step of the way, we shall more nearly achieve a nursing service that a community can be taught to consider adequate.

In public health nursing, we have been able to work out certain standards in administration, promotions, quality of work, amount of work, hours of service, Sunday work, increases in salary, vacations on salary, really because, behind most groups of public health nurses there is a keen and interested lay committee whose members are just as anxious that the sick poor and the small wage earner in their community shall be well nursed as they are anxious to get good nursing in their own households when illness occurs.

Must Keep On Learning

Public health nurses backed by such groups do not have to go to the alderman or to the overseer of the poor in the county in order to get their appointments and retain them. And yet that is often the way in which certain unsupervised, unprotected groups of public health and hospital nurses get their appointments, although upon the quality of their work may depend the health and happiness of future generations.

Schools of nursing are beginning to see that they must discuss plans more and more with boards of trustees when they try to get an adequate education for a young woman to whom they will ultimately give their diploma.

Although this proposal may seem like a tremendous task, through any good registry it should be possible to organize private duty nurses into groups so that their experience, skill and other qualifications will be recognized, their work explained and their good names protected by means of committees similar to those to whom public health nurses owe so much.

Sick people are selfish; their families are selfish for them. It was St. Catherine of Siena who reminded us that we should expect from the sick man only as much as he could give; that if he were as well as the people caring for him, he would not need their assistance. Consequently great powers of adaptation are required of nurses. Most nurses earnestly do their best to make these adjustments in behalf of their patients, and communities will sooner understand how much the nurse is trying to give when lay people are admitted into the inner circle and share with nursing groups the difficulties besetting them as groups and as individuals.

Dr. Richard Cabot once said that medicine was a noble profession but a horrible trade, or something to that effect. Most of us feel that the same may well be said of nursing; it is a high calling; it can be a great art. Nurses will never be adequately compensated for the service they render. Who can pay for a life that is saved or for a baby's good start?

Communities will receive a more nearly adequate nursing service when all three parties to this great contribution—the public, the physician and the nurse—remember that after all, their differences are few, their likenesses are many.

As nurses, we must keep on trying to learn more, so that we may give the very best there is in us, to those who need our service. If we constantly share with physicians and lay persons the secrets of our work, if we try to make them see how much in time, study and energy we give before we learn to give good nursing well, we shall educate two large groups of spokesmen.

By making the corner stone of our foundation the well equipped, well prepared nurse, we shall more nearly ensure for every patient, adequate nursing service. Nurses alone can never accomplish this. They must have the backing of the public and of physicians. And nursing must show constantly such excellent results that a now somewhat inarticulate public will become vocal in its requirements for good nursing, just as a well organized community demands safe water, safe milk or the finest type of teaching in its public school system.[1]

Closes Student Nurses' Training Course for Year

The University Hospital, Augusta, Ga., is not admitting any student nurses to its training course this year, according to a recent announcement.

Two members of the graduating class have been placed on the hospital pay roll for postgraduate work. If this plan is successful, more postgraduates will be taken on later to supplement the shortage of student nurses which is expected to occur toward the end of the year as members of the September class finish their training.

[1] Read at the meeting of the Illinois State Nurses' Association, Quincy, Ill., October 7, 1932.

What Sixty-Six Hospitals Think of the Central Unit Record System

By JOHN H. STOKES, M.D., RICHARD A. KERN, M.D., and L. KRAEER FERGUSON, M.D., Philadelphia

FUNCTIONING as a committee of the staff of the Hospital of the University of Pennsylvania, Philadelphia, we were confronted in 1931 with the task of gathering as much information as possible on the subject of central unit record systems for hospitals. The available literature on the subject yielded much that was of value, nevertheless it failed to answer fully a number of questions that would naturally be asked by the staff and the board of managers of an institution in which the installation of a central unit record system might be contemplated. We therefore sought data on record systems in use in a large number of hospitals comparable to our own institution in size or function or both. We also solicited opinions on various aspects of a central unit record system from officers of these hospitals, irrespective of the type of record system in use in these hospitals.

In the belief that the information so acquired might be of value to others who are faced with the same problem, and mindful of the magnitude of the task of gathering the material and of the strain on the patience of those supplying the data, we here place the results of the survey on record.

Before proceeding to the details of the study, it is advisable to define the terms used in this report, in order that the statement of the findings may be readily understood.

A Unit Record Defined

A unit record is defined as one in which all of the hospital records pertaining to a patient are assembled and handled in one container or folder, thus producing a complete record of out-patient and in-patient care, including each visit to or stay in the hospital and such notes as are pertinent to a follow-up system or social service data. It should be distinctly understood that the unit record in no way deprives any department of the privilege of using its own individual form of record; it means merely an assembling of the available data of a patient in a single container or folder. As Richard M. Pearce has stated, "The assembling of the constituent parts of the record and its storage must be arranged in such a way that the notes on a single patient may be readily and quickly procured as the occasion for their use arises."[1] This necessitates some form of central record system. We have found two types of this system in common use, the complete central record system and the partial central record system.

How Complete and Partial Systems Vary

The complete central record system concentrates the storage, filing, distribution, indexing and care of all records for all departments of both in-patient and out-patient divisions of a hospital in a central place and under a single authority or administrative unit. This means that the entire hospital record of a patient is kept available in a single folder.

The partial central record system has separate unit histories with appropriate central record rooms for individual hospital administrative rather than medical divisions such as: out-patient alone, in-patient alone, social service or private patients, the entire care of the records being under one administration or authority. The essential element of this group of record systems is multiple record folders which may be kept in one room or in separate rooms.

No central record system denotes no central authority and no type of unit record folder, a situation in which each medical department, subdepartment or person may have an individual record system. Even though such histories may be filed and stored in the same room, this arrangement does not conform to the principles of, or operate technically or administratively as, a central unit record system.

We investigated the problem from several angles. Visits were made to important hospitals having central unit record systems, including Presbyterian Hospital and the Cornell Clinic, New York City; Johns Hopkins Hospital and the University of Maryland Hospital, Baltimore; Boston City Hospital and Massachusetts General Hospital, Boston; the Mayo Clinic, Rochester, Minn., and Albert Merritt Billings Hospital, Chicago.

Published findings and recommendations of the

organized authorities concerned with hospital administration in America were consulted. This group included the American Hospital Association[2], the Association of Record Librarians of North America[3], the committee on hospital standardization of the American College of Surgeons[4] and the division of medical education of the Rockefeller Foundation.[1]

Representative Hospitals Were Selected

An inquiry was conducted into the record systems used in representative hospitals covering a geographic area from Peiping, China, to Boston, and from Montreal, Canada, to Atlanta, Ga. The institutions selected were comparable to the Hospital of the University of Pennsylvania in bed capacity, and many of them were comparable to it in their teaching function, but recognized public and private clinics were also included. The hospitals were further selected according to the number of significant scientific papers by members of their staffs published in two prominent medical journals during the past year.

Inquiries were sent to 84 hospitals and the replies received from 66 of them form the basis of this report. The hospitals from which replies were received are listed in Table I. The figures for bed capacity were based on data in the 1931 hospital number of the *Journal of the American Medical Association*.[5]

The scope of the investigation may be judged further from the fact that 48 of the 66 hospitals from which replies were received were in metropolitan districts, 40 were teaching hospitals, 12 were public (municipal or state) hospitals and 5 were large private clinics.

Questionnaire Was Easily Answered

The questionnaire was worded so as to make it easily and rapidly answerable, but was sufficiently comprehensive to include an inquiry into the broad principles of record keeping, storage, filing, distribution, control and cost. In addition to filling in the questionnaire, the signers added much helpful comment, and eleven additional letters were received which were of especial interest.

That the replies are authoritative is attested by the fact that the chief executive officer supplied the data in 53 of the 66 hospitals, the assistant executive officer in 4, and the head of the record division in 9. Thirty-four of the signers of the questionnaire were physicians.

The answers to the individual items of the questionnaire will be discussed separately. The replies were given in confidence, and for that reason no hospitals or officers are mentioned by name.

To Questions 1 and 2, relating to the type of record system used, all of the 66 hospitals replied. A central record system (complete or partial) is used in 60 (90.9 per cent) of the hospitals; 34 have a complete central record system; 26 have a partial central record system, classified as follows: Separate unit records and record rooms for ward and out-patient department, 11; separate unit records and record rooms for ward, out-patient department and social service, 5; central unit record system for wards only, 8; central unit record system for out-patient department only, 1; central unit record system for current out-patient department only, 1.

One of these hospitals having a partial central record system will install a complete central record system in the near future, when its new building is finished.

No form of central record system is used in 6 hospitals. In one of these, a research hospital, the records of each disease are filed separately. In another, the records are still bound in books. One hospital will install a central record system when it moves into its new building in 1932. The new superintendent of one hospital without a central record system approves such a system on the basis of his experience in two other hospitals. No special data are available on the other two.

Central Records Are Popular

The answers to Questions 1 and 2 show the almost universal use of some form of central record system in the hospitals replying. The size of the institution appears to bear no close relation to the type of record system used. Thus, the 34 hospitals with a complete central record system average 556 beds; the 26 hospitals with a partial central record system average 574 beds (the average is only 490 if the largest hospital in this group is excluded); the 6 hospitals with no central record system average 304 beds.

Question 3 contained an outline of the advantages and disadvantages of a central record system, every effort being made to include all the possibilities. Additional comment was invited. The signers were requested to rate their estimates of the advantages of the central record system on a scale of 0, 1, 2, 3, 4 (4 the highest rating). Answers to this question were received from 55 hospitals. The votes on possible advantages are listed in Table II as important or pronounced (4 and 3 ratings); relatively unimportant or trifling (2 and 1 ratings), and nonexistent (0). It appears from the table that the answers of the 55 hospitals replying are an overwhelming endorsement of the central record system.

Question 4 dealt with the disadvantages of the central record system in the same manner, a rating

of 4 indicating a decided disadvantage. Correspondingly, a rating of 0 as a disadvantage implies that no disadvantage of the type named exists. It will be seen from Table III that the disadvantages are largely rated as 0 or negligible. Answers to this question were received from 35 hospitals.

Two hospitals mention the difficulty of using a central record system because of widely separated buildings. Another disadvantage, listed once, is, "A central record system wears out records." This comes from an institution that has a central record room but files ward and out-patient records separately. One hospital declares that "The disadvantages outweigh the advantages of a central record system." This is an institution that does not have any central record system and that still binds its histories in volumes. A glance at the answers to this question shows that the disadvantages of a central record system appear minimal to the majority of the signers.

Questions 5, 6 and 7 were concerned with the type of building in which the institution installed its record system, the date of installation and the date of remodeling. Data or replies on the age of the building were received from 64 hospitals; the date of installation from 42, and the date of remodeling from 35.

Old Buildings House Most of the Departments

The age of the building (new or old) was not an important factor in determining whether a complete or a partial central record system was installed. Fifty-six per cent of the complete central record system installations and 58 per cent of the

TABLE I—HOSPITALS REPLYING TO QUESTIONNAIRE

Name of Place	*Bed Capacity*	*Name of Place*	*Bed Capacity*	*Name of Place*	*Bed Capacity*
Jewish Hospital of Brooklyn, Brooklyn, N. Y.	657	New York Post-Graduate Medical School and Hospital, New York City	426	Children's Hospital, Cincinnati	150
Allegheny General Hospital, Pittsburgh	405	University of Virginia Hospital, Charlottesville	340	Strong Memorial Hospital, Rochester, N. Y.	296
Indiana University Hospitals, Indianapolis	420	Rhode Island Hospital, Providence	600	Mt. Sinai Hospital, Philadelphia	316
Queen's Hospital, Honolulu, T. H.	300	Mt. Sinai Hospital, New York City	676	Mercy Hospital, Pittsburgh	670
University of California Hospital, San Francisco	287	Med. Coll. of Virginia Hosp., Richmond	448	University of Oklahoma School of Medicine and Associated Hospitals, Oklahoma City	447
Michael Reese Hospital, Chicago	356	Hospital of the Rockefeller Institute for Medical Research, New York City	60	Lankenau Hospital, Philadelphia	298
Vanderbilt University Hospital, Nashville, Tenn.	210	New Haven Hospital, New Haven, Conn.	434	Bellevue Hospital, New York City	2,190
Hahnemann Medical College and Hospital, Philadelphia	777	Methodist Episcopal Hospital, Philadelphia	248	Cleveland Clinic Hospital, Cleveland	275
Temple University Hospital, Philadelphia	358	Touro Infirmary, New Orleans	430	Hartford Hospital, Hartford, Conn.	721
Jefferson Medical College Hospital, Philadelphia	688	University Hospitals, Cleveland	379	Mayo Clinic, Rochester, Minn.	1,167
Presbyterian Hospital, New York City	732	University of Chicago Clinics, Chicago	333	Toronto General Hospital, Toronto	1,027
New York Polyclinic Medical School and Hospital, New York City	287	Buffalo General Hospital, Buffalo, N. Y.	406	University of Minnesota Hospital, Minneapolis	400
Union Memorial Hospital, Baltimore	312	St. Mary's Hospital, St. Louis	595	Grace Hospital, Detroit	403
St. Francis' Hospital, Hartford, Conn.	580	Harper Hospital, Detroit	657	Peter Bent Brigham Hospital, Boston	247
Passavant Memorial Hospital, Chicago	198	Receiving Hospital, Detroit	650	University Hospital, Ann Arbor, Mich.	1,221
University Hospital, Baltimore	263	Minneapolis General Hospital, Minneapolis	742	Louisville City Hospital, Louisville, Ky.	415
Stanford University Hospitals, San Francisco	342	St. Luke's Hospital, Chicago	650	Presbyterian Hospital, Chicago	412
University Hospital, Augusta, Ga.	257	Cincinnati General Hospital, Cincinnati	850	Peiping Medical College Hospital, Peiping, China	286
Henry Ford Hospital, Detroit	574	Buffalo City Hospital, Buffalo, N. Y.	836	New England Deaconess Hospital, Boston	180
Massachusetts General Hospital, Boston	414	Long Island College Hospital, Brooklyn, N. Y.	480	Royal Victoria Hospital, Montreal	700
Clifton Springs Sanitarium, Clifton Springs, N. Y.	500	Western Pennsylvania Hospital, Pittsburgh	651	State of Wisconsin General Hospital, Madison	493
City Hospital, Cleveland	1,440	Denver General Hospital, Denver	553		
		Johns Hopkins Hospital, Baltimore	845		

partial central record systems are in old buildings. In other words, old hospitals have been as willing as new hospitals to install complete central record systems.

There has been a decided trend toward the installation of complete central record systems in recent years. Of 34 complete central record systems, 11 have been installed since January 1, 1926, and 15 others have been remodeled to conform to the central record type. Two other institutions will install complete systems next year. Of 26 partial central record systems, only 2 have been installed since January 1, 1926, and 4 others have been remodeled.

Distributing the Records

Questions 8 and 9 were concerned with record distribution problems. Replies were received from 64 hospitals. With the installation of a complete central record system there is a shift toward some type of mechanical distribution to supplement messenger service. Nineteen of 26 hospitals with a partial central record system and 17 of 34 hospitals with a complete central record system depend on messengers only. Four of 26 hospitals with a partial central record system and 16 of 34 hospitals with a complete central record system have some form of mechanical distribution. There is no decided preference for any particular type of mechanical distributing apparatus. There is no available information as to which form is cheapest or which is most efficient.

TABLE II—POSSIBLE ADVANTAGES OF A CENTRAL UNIT RECORD SYSTEM

	Number of Votes		
	Rating 4-3	*Rating 2-1*	*Rating 0*
Facilitates statistical work	41	1	1
Increases accessibility of information	39	1	0
Raises and enforces higher standards of records	38	0	1
Gives better grasp of case	36	3	1
Gives general knowledge of treatment	36	4	0
Favors individual research	33	5	1
Avoids reduplication	32	6	1
Minimizes needless references	32	6	1
Economizes time	31	7	1
Economizes personnel	28	6	5
Raises and enforces higher standards of practice	28	7	3
Economizes space	27	9	4
Economizes material	22	12	3

Three reports checked endorsement of all the advantages, without ratings.

To Question 10, "Are records sent out of the hospital for study?" answers were received from 62 hospitals. In 35 (56 per cent) hospitals, records may not be taken from the hospital buildings. In 27 (44 per cent) hospitals, records may be removed from the hospital building for study. This was noted "under supervision" in one report, and "doctors' offices only" in another.

To Question 11, "Who may withdraw records?" answers were received from 62 hospitals. In 22 hospitals no person is permitted to withdraw records from the hospital building for study. Permission to withdraw records from the building for study is given to staff members only in 31 hospitals; staff members and heads of departments only, 5 hospitals; staff and interns, 1 hospital; staff, interns and students, 1 hospital; staff, interns and nurses, 1 hospital; staff and social service, 1 hospital. From these figures it appears that it is the policy of most hospitals to restrict the privilege of withdrawing records from the premises for any purpose.

To Question 12, concerning the space available in the record division for study of records, answers were received from 58 hospitals. There was an adequate separate room or rooms in 26 hospitals; adequate space (not described), in 6 hospitals; inadequate separate room, in 5 hospitals; inadequate space (not described), in 8 hospitals; desk space only, in 9 hospitals; no space available, in 5 hospitals. Those hospitals admitting that they had inadequate facilities did so with regret. It is apparent that the provision of adequate space for study purposes in the record quarters is recognized as a requirement for adequate service.

Questions 13 and 14 dealt with the supervision of records by the record division. Replies were received from 64 hospitals. The record division has the authority to enforce standards of diagnosis, classification and nomenclature in 48 hospitals (74 per cent). It has authority over nomenclature in only 3 hospitals. It has no authority in 13 hospitals. The record division of 63 hospitals has the authority to check or criticize the completeness of routine patient examinations in 41 hospitals (60 per cent). It has no such authority in 22 hospitals.

Who Supervises the Records?

To Question 15, regarding how authority in matters of record control is exercised, 61 hospitals replied. A staff committee supervises records in 19 hospitals. This committee is composed variously as follows: record committee of the medical board in 14 hospitals; the chairman of the record room committee in 2 hospitals; staff record committee appointed by the superintendent in 1 hospital; executive committee of the active staff in 1 hospital; chiefs of staff through the record committee in 1 hospital.

In 16 hospitals the following administrative officer supervises records: the medical director, 3; the assistant director, 1; the superintendent, 9; the chief resident physician, 2; "hospital administration," 1.

The hospital staff supervises records in 13 hospitals. This supervision is exercised by: chiefs of staff in 10 hospitals; the president of the staff in 1 hospital; the medical board and heads of divisions in 1 hospital; the staff censor of records in 1 hospital.

The chief record librarian supervises records in 14 hospitals; in two cases the librarian is noted as "under supervision of staff." No data were obtained from 5 hospitals.

Factors Influencing Private Patient Records

To Question 16, "Are records of private patients kept in the central record room?" 61 answers were received. The question was not applicable to 9 hospitals, 2 of which were private hospitals and 7 of which had only ward patients. Of the 52 hospitals from which significant answers were obtained, private patient records are kept in the central record room in 49 (94 per cent); in 3 hospitals private patient records are not kept in the record room. It appears, therefore, that the existence of a group of private patients in a hospital is not regarded as a bar to the successful use of a central unit record system.

Question 17 concerned the method of handling private and charity or ward patient records. Answers were received from 60 hospitals, 9 of which were all-ward or all-private hospitals, to which this question did not apply. Of the remaining 51 hospitals, the replies indicate that all records of ward and private patients are handled in the same way in 41 hospitals (80 per cent). In 8 hospitals (15.6 per cent) private patients' records are kept in the central record room and handled as ward records, with the following differences: Private records differ from other records only in the color of the folder in 1 hospital. Private records are stamped "private" and are never used for study in 1 hospital. They are used only when permitted by the attending doctor in 3 hospitals. The blood Wassermann report is not placed on private records in 1 hospital. A few records of psychiatric cases are not placed in the central record file in 1 hospital. Records of "courtesy staff" patients are not included in the central record room in 1 hospital. A separate file is maintained for private patients' records in 2 hospitals (4 per cent).

Thus it appears that in 80 per cent of the hospitals all records, private and ward, are handled in the same manner. In about 8 per cent there are restrictions as to the use of private patient records for study. In 2 hospitals only is confidential information withheld from the record. In only 2 hospitals (4 per cent) is it considered necessary to maintain a private patient file.

Question 18 dealt with budget and annual cost. In 14 hospitals a definite sum was set aside as the record room budget. In 20 hospitals there was no record room budget as such. No data were received in 32 replies.

The figures received of the annual cost of the record system are difficult of interpretation for they vary from $2,160 yearly to $37,000 and bear no close relation to the bed capacity or location of the hospital. The annual cost per bed of central unit record systems ranges from $5.14 to $63.08. The cost of the personnel per person ranges from $114 to $3,181 per annum. An average cost per bed is $25.32. It is evident that cost must depend on local conditions and the elaboration of the system and need not be prohibitive.

TABLE III—POSSIBLE DISADVANTAGES OF A CENTRAL UNIT RECORD SYSTEM

	Number of Votes		
	Rating 4-3	*Rating 2-1*	*Rating 0*
Heavy initial outlay in old quarters	8	3	12
Delays individual patient handling	5	7	17
Makes departmental treatment recording difficult	5	2	21
Costly in excess of advantages	4	2	19
Multiplies red tape needlessly	4	2	20
Loss and displacement of records serious	3	4	22
Standards unenforceable	3	1	24
Impedes individual research efforts	2	2	21
General statistics of little value	1	7	16

Cost Data Were Not Adequate

Question 19 attempted to ascertain an estimate of the cost of installation of a central record system and the results were not successful. Answers were received from 4 hospitals, in which the amounts ranged from $2,189.50 to $8,500. One teaching hospital of 700 beds installed a central record system in an old building in 1931 for $8,500; a second teaching hospital of 426 beds installed a central record room in an old building in 1930 for $5,000. Figures on this matter will evidently vary with individual hospital conditions and problems.

Question 20 dealt with the personnel of the record division. The number of persons employed in record divisions varies widely, regardless of the size of the hospital. Some hospitals of from 200 to 300 beds have a record division personnel of 10

to 12, whereas other hospitals of 700 to 800 beds have a personnel of only 3 or 4 to 7. An analysis of the replies shows that of hospitals having a complete central record system, those with 600 beds or less average 5 to 7 record division personnel. Those with more than 660 beds average 16 to 23 personnel. Hospitals having a partial central record system (these were mostly institutions with a central record system for the out-patient department only) irrespective of bed capacity, average 5 to 8 personnel.

It is evident that personnel, like cost, depends upon the elaboration of the system. One hospital of 730 beds with a complete central record system had a personnel of 40, while another of 660 beds had a personnel of only 7; both hospitals used messenger distribution.

When a Unit History Begins

Question 21 asked, "Have you a medical officer or central bureau that medically examines all patients before admission to the wards or the out-patient department?" A consideration of this subject falls closely in line with that of a central record system because, whether there is a complete or a partial central record system, the patients must pass through some central unit where each is given his individual number and where the assembling of a unit history is begun. For this reason we appended to the questionnaire on central record systems the inquiry stated at the beginning of the paragraph.

Answers to this question were received from 58 of the 66 hospitals, as follows: In 24 (46.5 per cent) there is a central admitting officer or bureau which functions for both the wards and the out-patient department. In 5 there is a central bureau for ward admissions only. In 3 there is a bureau for the out-patient department only. Twenty-six have no such bureau or medical officer. Thus it appears that approximately half the hospitals questioned recognize centralized admission with distribution on the basis of medical examination as essential. An additional 15 per cent employ this plan in part.

In summarizing the data gathered from the questionnaire we find that organizations concerned with hospital administration are unanimous in their recommendation of a central unit record system. An analysis made from the 66 replies has shown that:

1. A central unit record system is used in some form in 60 (90.9 per cent) of these hospitals; complete central unit record systems are used in 34 hospitals, while partial systems are used in 26 hospitals.

2. The advantages of the system far outweigh the disadvantages in the opinion of the signers of our questionnaire.

3. A central record system may be installed to advantage in an old building. Fifty-seven per cent of the installations of central record systems were made in old buildings and the trend has been toward complete rather than partial systems.

4. The large majority of hospitals employ messenger distribution, though there has been a tendency to supplement messenger with mechanical service.

5. In 56 per cent of the hospitals replying, records are not permitted to leave the hospital buildings; in 44 per cent records may be withdrawn for study by the staff at large or by the ranking members of the staff.

6. Of 58 hospitals, 32 provided adequate space for record study near the record room.

7. The record division policy is controlled, with respect to diagnostic classification and nomenclature, by: (1) the staff committee in 19 hospitals; (2) the chief administrative officer in 16 hospitals; (3) the hospital chiefs in 13 hospitals; (4) the chief record librarian in 14 hospitals.

8. The record division and its supervising authority have power to enforce standards of nomenclature and diagnosis in 73 per cent of the hospitals. It may check and criticize the completeness of routine patient examinations in 60 per cent.

9. Private patient records are kept in the central record room in 94 per cent of the hospitals answering this question, while in 80 per cent private and ward records are handled, stored and used in the same manner.

10. The yearly cost of a central record system varies greatly with local conditions and the elaboration of the system. Per bed cost ranges from $5.14 to $63.08.

11. Figures received regarding cost of installation are too few to be interpreted.

12. The personnel of the record division varies somewhat according to the size of the hospital and the type of system used. The average numbers for the complete system are 5 to 7 persons for 600 beds or less; 16 to 23 persons for more than 600 beds.

13. Of 58 hospitals, 32 have a central bureau or officer which medically examines all patients admitted to both the in-patient and out-patient departments. In 26 there was no such bureau or officer.

References

[1]Pearce, Richard M.; Methods and Problems of Medical Education, The Rockefeller Foundation, New York City, 1926.

[2]MacCurdy, Frederick, Unified Patient Admission, Trans. Am. Hosp. Ass'n, 1930, vol. 32, p. 701.

[3]Babcock, Florence G., and Waugh, William C., Bull. Ass'n of Record Librarians of North America, March, 1931.

[4]Turner, Joseph, Record Room Filing—A New System, Bull. Am. Coll. Surgeons, 1931, vol. 15, p. 43.

[5]Jour. Am. Med. Ass'n, 1931, vol. 96, p. 1023.

The Problem of the Month:

Should the Graduate Nurse Work Without Salary?

DURING the next twelve months hospitals are going to see many changes in their procedures and there is a probability that an entirely new philosophy of hospitalization will be devised.

When change occurs there are always conflicting points of view and it is the intention of THE MODERN HOSPITAL through this department to present the best obtainable thought on various subjects of timely interest.

For this month the question, "Should or should not graduate nurses work for their board, room and laundry?" was sent to seven hospital administrators representing different types of hospitals in different sections of the United States. Their views are set forth here.

This question has been raised in connection with present economic conditions. Many graduate nurses who are penniless have applied to hospitals for work and have been willing to accept a bare living for their services. Should hospitals take them in?

They are not replacing other graduates but probably are replacing student nurses. In view of the present tendency to reduce the number of student nurses, is this all right?

Is it an injustice to other nurses, should the hospital pay a small stipend, should they hire more nurses at shorter hours, so as to give more work to graduates? What have you done, what do you think?

Dr. Donald C. Smelzer, Director, Graduate Hospital of the University of Pennsylvania, Philadelphia:

"This is a question that must be settled primarily by the nurse and secondarily by the hospital.

"We think that if the nurse voluntarily applies for work under such conditions, we are justified in accepting her services, and in return we will give her the type of work that will be of material benefit to her in the future. In other words, she will be placed on duty in a specific department, such as the operating room, the eye, ear, nose and throat, medical or bronchoscopic departments, and will be given every opportunity to 'brush up.' We shall not reduce either our graduate personnel or our pupil nurse staff on account of this additional service.

"It seems to me that it would be foolish for hospitals to undermine their training schools by using the services of graduate nurses who are willing to work for their maintenance. This condition is undoubtedly only a temporary measure, and when times improve the hospitals which have resorted to this means of saving money will find themselves in a worse condition than they are in at present.

"The hospital must not exploit the misfortune of the graduate nurse. The fact that the nurse is permitted to work in the hospital for her room and board should be looked upon by all concerned as a generous aid on the part of the hospital, and the nurse will receive in what amounts to postgraduate training, to say nothing about the maintenance, at least an equivalent value for the service she renders to the hospital.

"We have taken several graduate nurses on this basis. They are free to leave any time they choose and they may return whenever they desire. All we ask is that they obey our rules and regulations and that their hours on the wards conform to the eight-hour duty basis, as do our regular paid personnel.

"There is no night duty and no 'made' work."

Dr. B. Henry Mason, Superintendent, Waterbury Hospital, Waterbury, Conn.:

"I presume there are some communities in the country at the present time where, as a result of the depression, people of means have been forced to practice economy in unusual ways, so that there are graduate nurses on the registry who have not been able to receive sufficient work to meet the necessary living expenses. That condition does not exist at present in Waterbury. Should it exist however, the Waterbury Hospital does not have adequate housing accommodations to take on any number of graduate nurses who might be willing to work for their board, room and laundry.

"I feel that for an institution to allow graduate nurses to work full time for only board, room and laundry would be harmful to the morale of the nursing group, and that the quality of nursing

service rendered would ultimately be lowered. In other words, it would be generally detrimental to all parties concerned. Where unemployment among graduate nurses has reached an emergency status, I feel that a plan that would offer a few additional hours of work in excess of what might be required to meet the cost of board, room and laundry, which would allow graduates to receive a small reimbursement beyond maintenance, would be more helpful. Anything short of that would, in my opinion, be taking undue advantage of an unfortunate situation.

"At Waterbury, the adoption of an eight-hour day for private duty nurses has definitely helped relieve unemployment among graduate nurses, as per our letter to THE MODERN HOSPITAL.[1] It appears that during these times of stress, unemployment is not absolutely hopeless among graduate nurses, for most of them can receive a sufficient amount of private work or work in some manner as stated above, so that probably none of them will be required to exist on charity, whereas in many other lines of endeavor the individual's existence is narrowed down to charity, as there is no other possible alternative."

Dr. Joseph Turner, Director,
Mt. Sinai Hospital, New York City:

"When needs become urgent and help must be had at any price, there is an understandable tendency to abandon standards of service and reward which have been achieved over many long years. The plight of graduate nurses who in desperation offer to work for their board, room and laundry can be understood; to take advantage of the situation for the benefit of hospitals or other groups is indefensible. As a practical relief measure, however, and for relief purposes only, any plan which will help nurses (or any group for that matter) to weather the present economic storm deserves consideration and adoption, provided that by doing so none of the nursing or other groups which are regularly employed for definite and routine services are dislodged or compelled to accept lower salaries.

"The Mt. Sinai Hospital has participated in relief programs during the past two years by providing work for unemployed in the nonprofessional grades. More recently this has been extended to a limited number of graduate nurses, particularly recent graduates who, on completion of the school term, had no prospect of a successful self-supporting venture in the field of private duty nursing or who could not find places in full-time positions. As a practical relief measure, a number have been taken into the hospital to supplement the regular staff of graduate nurses and student nurses on general floor duty. These nurses are provided with full maintenance and receive in addition a substantial stipend, funds for which have been provided for a limited period. It is hoped that additional sums will be forthcoming to permit a continuation of the allowance.

"No advantage is being taken of the distress and need of these nurses, they are not being exploited, they are not being substituted for the regular staff of nurses, and their presence does not disturb the established salary schedules for the permanent personnel."

Maurice Dubin, Director,
Mt. Sinai Hospital, Chicago:

"My answer to this question is unreservedly and emphatically in the negative. This would mean exploitation of the nurse and exploitation surely should have no place in the scheme and philosophy of a social agency such as a hospital. I assume, of course, that the question as propounded implies full-time duty with the remuneration in the form of board, room and laundry. If the hours of service rendered in return for maintenance are proportionate to the value of the maintenance the question would define itself, as I view it, as part-time work for pay.

"With the question defined, my answer is, I think, best given in a brief outline of what we are doing at our hospital to help overcome the unemployment of graduate nurses which we assume occasioned the question:

"1. We have reduced the enrollment of students.

"2. We have placed a limited number of graduate nurses desirous of an opportunity for further postgraduate study in public health nursing, social service and allied fields on a schedule of approximately one-third time, for which they receive maintenance. We estimate that complete maintenance is equal in value to one-third of the pay allowance to graduates.

"3. We have placed graduate nurses and supervisors on half-time duty with half-time pay and full maintenance, thereby doubling the number of graduates we ordinarily employ.

"We believe the last step is essential in providing employment for nurses. If universally adopted in the hospital field it would not only overcome existing unemployment but would ultimately lead to better standards both in the care of the patients and in nurse employment. With improved economic conditions this half-time work could be increased to two-thirds time. This, coupled with higher sal-

[1]Doctor Mason's plan was published in the December issue of THE MODERN HOSPITAL, p. 84.

ary rates as business conditions improve plus the maintenance allowance, always a factor in a nurse's livelihood, would result in a universal eight-hour day for graduates with commensurate pay and ultimately, perhaps, a six-hour day. A six-hour day is about all that the conscientious nurse who attempts to anticipate and satisfy every desire of her patient can stand without endangering her health. It is our belief that efforts in the direction of fewer hours of duty will ultimately lead not only to more employment of nurses and better standards of work for them, but also better standards of care for the patients."

Grace Crafts, Superintendent,
Madison General Hospital, Madison, Wis.:

"This period of unemployment is a difficult time for the nursing profession as a whole and the private duty nurses especially. Economic conditions call for close cooperation between the graduate nurse and the hospital. I feel strongly that hospitals should be helpful and sympathetic, and should not take advantage of the unemployed nurse. To accept from her a full day's work for room, board and laundry is, in my opinion, most unfair and takes advantage of her helpless situation.

"Hospitals can use unemployed nurses for three hours a day, giving them their board and laundry, their laundry to include uniforms used on duty. This service should not replace the service of the graduate staff which is already employed. We have used this method in our institution, allowing the private duty nurse to remain on the registry and take her call if she is fortunate enough to receive one.

"Those administrators living in a college town are familiar with student help and I feel that we should not ask any more of the nurse than we do of students in such a position. If we increase our graduate staff in the future, no doubt we shall plan the work so that the nurse will be employed for shorter hours in order that more graduates may be put to work."

Dr. Maurice H. Rees, Director,
Colorado General Hospital, Denver:

"We have not been in favor of giving board, room and laundry to unemployed nurses in return for a limited amount of service. Our objections to such procedures are as follows:

"First, nurses working for board, room and laundry only, as a rule give very inferior service and often are not worth even the maintenance service.

"Second, no hospital budget at the present can bear the expense for the additional board and laundry.

"The following method has been tried in Colorado General Hospital during the past year:

"For several months the unemployment relief fund of Denver sent us a limited number of nurses who were paid $35 a month by the relief fund. The hospital furnished only board and laundry. These nurses worked eight hours a day for six days a week. When the unemployment fund was exhausted, a number of our graduate nurses volunteered to take one month's leave without pay. Each graduate was relieved by two nurses who divided the salary and maintenance allowance. At the present time the method is as follows:

"When a nurse resigns the salary and maintenance allowed for the position are divided between two nurses. Under this scheme the limit is eight part-time nurses. In all instances the so-called part-time nurses work eight hours a day for six days a week."

J. B. Franklin, Superintendent,
Grady Hospital, Atlanta, Ga.:

"During this period of economic depression, I consider it the privilege as well as the duty of all hospitals to take care of their own to the limit of their ability.

"I do not think graduate nurses should be discharged to make room for cheaper labor, but when vacancies occur, due to resignations or any other cause, the same amount of salary expenditure can and should provide for more than one nurse when practicable.

"I also think graduate nurses, in a limited number, so as not to upset the balance of the training school, can be used on general duty, instead of taking in more student nurses, and on terms and conditions similar to those offered students. This will serve the double purpose of relieving the stress among graduate nurses and reducing the number of student nurses. At the same time, these graduate nurses should be given special training and special instruction so that their service may serve as a postgraduate course.

"No one can rightfully object in these times to hospitals taking on additional nurses on reduced pay, so long as these nurses are not displacing others on regular pay, and so long as hospitals are honest and fair and use the additional help as a temporary relief measure.

"In Grady Hospital we are resorting to the different measures referred to above in order to help, particularly, our own graduates, and we feel that in so doing the hospital is rendering a valuable service."

Editorials

Progress in Hospital Economics

THE report of the Committee on the Costs of Medical Care featured hospitals to a remarkable degree. As the review of the report in last month's issue suggested, hospitals are not only described as to their general importance, professional requirements and financial needs as they exist at present, but are presented as certain to occupy an even more central position in the general medical service to the people of the United States in the future. A large part of the practical recommendations of the committee center about the hospital or suggest plans through which hospital and clinic service can be better supported or made more widely useful.

Hospital administrators, living as they do at the crossing of many ways, endeavor to avoid controversy. Some of the issues involved in the cost of medical care have been made a matter of controversy; others are noncontroversial. In the noncontroversial area is the matter of group hospitalization, for example, to which an important article in this issue of THE MODERN HOSPITAL is devoted. Since under the plans therein described, this includes only the payment of the hospital bills themselves and does not affect charges to patients for professional services, the matter rests primarily within the province of the hospital administration itself in direct relationship with the public. It is, of course, a matter about which the professional staff of a hospital should be kept informed.

The extended use of hospital buildings to provide, with or without rental, space for offices or office hours during which physicians of the staff may see private ambulatory patients is another recommendation upon which all sections of the Committee on the Costs of Medical Care agreed and upon the merits of which when local conditions make it practical, there can be little difference of opinion.

The majority report of the Committee on the Costs of Medical Care recommended comprehensive plans of insurance against sickness. Several significant examples of such enterprises now active in different parts of the country in which hospitals and clinics participate were described. This majority report was signed by thirty-five of the forty-eight members of the committee and endorsed in substance by two more. Eight physicians signed a minority report objecting to many of the majority group's chief recommendations and particularly to sickness insurance, but seventeen of the twenty-five physician members of the committee signed the majority report.

The needs of the public for more adequate medical service, as brought out in the scientific reports of the committee, must always be kept in mind. The facts of the situation from the standpoint of the general public, the medical and allied professions, and the hospitals must be considered dispassionately. It is most desirable that the discussion of this subject shall be maintained on a high plane and this is essential within the hospital organization where the administration, the medical profession, and the public have interests so closely interrelated.

The administrative officers of hospitals depend upon the community for moral and financial support and must maintain policies that are in accord with the demands of the community as well as with the needs of the patients and the professional staffs of their institutions. Satisfactory working relations with all of these three groups must be maintained but the ultimate responsibility of a hospital is to the community. In fact, with the exception of the relatively small number of proprietary institutions, it is obvious that the public owns the hospitals since they are not run for profit. More than that, the private charitable institutions, the voluntary hospitals, are a gift to the public.

The Hospital and the Medical Staff

THERE is not a home in this land that does not at some time experience the need for the counsel, the guidance, the understanding moral support of the family physician.

The sense of prideful proprietorship with which the average citizen speaks of his physician is ample evidence of the intimate place that the doctor holds at his fireside. The physician serves in a liaison capacity between the community and the hospital. He is often sponsor for the efficiency of the local institution. This relationship to be of the greatest mutual aid to the community and the hospital should be recognized and nurtured.

The relation of the physician to the management of the hospital must be no less definite. The hospital itself represents in reality a second and smaller specialized community living and working within a larger one. To bring the doctor into closer and more sympathetic relationship with all the angles of institutional activity is not a simple problem. What matters the presence of a splendid personnel and equipment if they are not so guided

and utilized as to bring the greatest and speediest good to the sick?

Recognizing these facts, as must all who have given serious thought to the problems involved in the institutional care of the sick, THE MODERN HOSPITAL is inaugurating in this issue a new department which will be devoted to the discussion of matters which specifically concern the intramural professional activities of the hospital and generally the practice of medicine. While the rationale of diagnosis and therapeutics will not find a prominent place in these columns, yet there will be given not a little space to the description of scientific procedures and the apparatus employed therein.

This innovation will in some measure exemplify the belief of the editors that no definite line of cleavage should exist between the administration of the physical plant of the hospital and the practice of the principles by which disease is discovered, identified and alleviated. It is confidently expected that this plan will justify itself in a measure at least by definitely broadening the scope of usefulness this magazine endeavors to maintain.

The Commission on Medical Education Reports

THE Final Report of the Commission on Medical Education, just released for public perusal, is in its epochal potentialities second only to the 1910 Report of the Rockefeller Foundation made by Abraham Flexner. The new volume, finely edited and indexed, is more than a committee report. It is a reference work teeming with historical and informative data, which bids fair to influence the trend of medical and sociologic thinking in no uncertain way for many years to come.

Prior to 1910, medical education was in such a chaotic state that although 162 medical colleges were in existence, the lack of any standardization of curricula made possible the graduation of such poorly trained students that the degree of doctor of medicine was often but a mockery. When the Rockefeller report was published an enlightened public and press at once demanded a remedy. In half a decade thirty-five weak and inadequate colleges closed their doors and in less than three decades more, the number remaining had declined to seventy-six. The Rockefeller report had shown the way and an aroused profession had developed the practical remedy.

The Commission on Medical Education has again directed attention to the faults of the present system of medical education. With finely balanced judgment it has pointed to the vital need for well trained medical practitioners. It has recognized that good medical care is costly but it has insisted that ways be found to provide it for the people. It has not joined its voice with the present hysterical clamor for saving dollars at any cost. It suggests the dangers incident to the development of the specialties. Sick men and women should be heard when they refuse to become merely a collection of disassociated organs, each requiring an especially trained mechanic. It places squarely before a responsible public the fact that the education and the moral and ethical attributes of the doctor are paramount and that all else is secondary in importance. While the cost of medical care is acknowledged to be high, the blame therefor does not always lie at the doctor's door. The average physician is equipped to handle a large percentage of illnesses without the aid of the specialist or even of the hospital. But the public often will have none of it. It demands specialists and special examinations which are often as unnecessary as they are costly.

Of especial interest to the hospital field is the commission's discussion of the relation of the internship to the adequate training of the physician. The intern is handicapped if he is permitted to lean too heavily on laboratory methods during his hospital days, it is pointed out, and the necessity for the existence of a teaching atmosphere is insisted upon. That state board examinations for those graduated both from a recognized school and from a hospital are unnecessary and ineffectual in deciding who are qualified to practice medicine is apparently the opinion of the commission. This view is held by many other medical educators.

That the average medical curriculum is top-heavy with theory and scanty in practical experience and teaching is the growing conviction of thoughtful persons. A return to case teaching, less of the spectacular in the conduct of large clinics and an insistence on the importance of a knowledge of the fundamentals of disease detection, treatment and prevention are the logical trends of the day. If medical colleges would more fully perform their plain duty in preventing the morally, physically and intellectually unfit from reaching the senior class, if qualities of character as well as of learning were more routinely recognized, the charlatan would not so often be found practicing his nefarious trade. Medical schools have been grossly culpable in this respect. The state board is of no avail in detecting in those who apply for a medical license character traits that make them a menace to the trusting public.

That the plight of the sick will be measurably ameliorated as a result of this splendid study is the belief of the editors of THE MODERN HOSPITAL.

The Executive at Sea

THE hospital administrator who indulges in the good habit of an occasional trip abroad to discover how the Old World solves the problems from which he has just freed himself for a while, cannot fail to be impressed at the outset by the similarity between his work as the executive of a hospital and the work of the master of the ship on which he has taken passage.

Like everywhere else in life there are resemblances as well as differences between the two, and these attract the hospital man early in the voyage when he may be casting about restlessly for something to distract his mind from the swaying influence of the sea. Aside from the captain's trim uniform, with its bright decorations giving silent testimony to years of varied service, which is so captivating to strangers on board ship and commands so much respect (a detail the administrator may miss in his daily work) the skipper has much from which the hospital man may learn.

The responsibility for the safety of large numbers of human lives is almost the same in both instances. In the one, however, it is undivided while in the other it is taken to be a function that can be delegated to others. The supervision of departments presents similarities though, to take a familiar example, the chief engineer of the ship is placed in a position where he must be self-reliant and resourceful in the absence of a ready-to-hand consultation system. The chief steward must take a variety of tastes into account even if he has no therapeutic diets to consider. Experience with his department reminds one of a certain petty official on the wards of the hospital who, like the ubiquitous steward on the ship, must have his palm greased in accordance with set traditions. In one case the obligation comes at the end of the voyage, and depends on the quality and quantity of the service rendered, while in the other it is often a matter of payment in advance, since you never can tell the prognosis of a disease too accurately. So far as labor turnover is concerned there can, of course, be no swapping of horses in midstream.

It is in the matter of navigation that the administrator of the hospital may have to learn much from the administrator of the ship before he can claim kinship with him. The obligation to steer a straight course is there for both, but there is no "back seat" driving at sea. The captain fears the fog more than he fears the storm. He makes use of instruments of precision in guiding his vessel.

One haunting thought follows the hospital administrator when he sets foot on land and that is the ability of the captain to isolate himself on the bridge and surround himself, undisturbed, with men of technical ability when he has a problem to solve that concerns the safety of those who are entrusted to his care for the voyage. There are lessons to be learned everywhere, but one must be on the high seas to experience the thrill of knowing, by the best of proof, the value of sound and efficient executive service.

The Buyers' Market

MUCH has been spoken and not a little written in recent months about the methods by which a financial retrenchment in the affairs of the hospital can be brought about.

Every possible effort is being made to reduce maintenance costs without materially lessening the service to the patient. All such strivings are, of course, laudable. But there has never been a time, at least in recent years, when the purchasing power of the hospital dollar has been as great as now. The cost of food as well as of many other supplies has declined in some instances at least 25 per cent, as compared with such costs a few months ago. Building costs have likewise shown a sharp decline. Whereas less than two years ago cubic foot costs ranged in some instances as high as one dollar, today contracts for fireproof hospital construction are being let at a figure which is approximately 50 per cent of this amount. Architects and builders who in fairer economic weather scorned contracts which did not boast of at least six figures now are avid for business much more meager in proportions. This is surely a buyers' market.

Not a few institutions with a firm and we believe justifiable faith in the future are thriftily taking advantage of present day economic and labor conditions and are carrying on building operations of pretentious dimensions, saving thereby many thousands of dollars. Major repair projects can be performed now by the hospital at great profit. The replacement of old roofs, the renovation of plumbing, the rearrangement and refitting of hospital rooms and wards, the landscaping of grounds, the replacement of old and inefficient sterilizer apparatus, the purchase of beds, now will represent good dividends on the money invested.

Fortunate indeed are those institutions that possess both the vision and the funds to take advantage of present day prices. Everywhere there are signs of a restoration of confidence in the institutions of this country. When the hospital possesses a buying power in excess of that required for providing the mere necessities, purchasing now for future use, whether it be buildings or bandages, is an example of sound business judgment.

Practical Administrative Problems:

Hospital Emergencies and How to Meet Them

IN THE average general hospital when a patient develops a psychosis a real emergency confronts the administrator. Because of the comparative rarity of this occurrence and since experience in handling such patients is often meager, much uncertainty is likely to exist as to the proper nursing of the patient and the best methods of protecting the reputation of the hospital by preventing an attempt at self-destruction on the part of the patient.

Frequently suicidal or homicidal acts occurring outside the hospital create the need for emergency hospital care. In a succeeding article will be discussed the institutional care of the psychotic or delirious patient. At this time will be pointed out methods by which patients suffering with a depression, who have endeavored to end their own existence, should be received and treated in the accident ward of the hospital.

Full Equipment Needed in Accident Ward

It is to be regretted that during the past few months most institutions have been more often required to render first aid to those who because of a mental depression attempted self-harm, than perhaps during any similar period for many years. To be sure, when a patient is received suffering from a gunshot wound or a severed artery, the treatment differs not one whit from that which is necessary when such traumata are purely accidental. And yet it is of importance, whether the damage has been done through an ingestion of some harmful substance or whether a laceration or puncture of tissue represents the chief disability, to determine the reason for the injury in order to provide a safe routine for such a patient's after care.

The hospital, of course, cannot be responsible for any injury which has taken place prior to the admission of the patient, but it can be held to account for the protection of the patient's welfare once he has been admitted thereto. It is the particular purpose of this sketch to discuss briefly the emergency and after treatment of poisonings that have resulted because of the ingestion of a chemical, with suicidal intent. Often in the confusion incident to the reception of such a patient some important matters are overlooked. Inquiry as to the circumstances surrounding the occurrence should be carefully made. This of course should be done by someone not delegated to the work of first aid. The careful preservation of weapons or drug containers is essential because of their importance in later legal proceedings. The names and addresses of witnesses or of those bringing the patient to the hospital should of course be carefully recorded on the history sheet of the patient. Later a description of all wounds such as bruises, abrasions, contusions or heat or escharotic burns observed on the body of the patient should be set down on this sheet.

The accident ward of the hospital should be physically equipped to care for all types of poisonings. Its personnel, both medical and nursing, must be thoroughly instructed in the methods of administering emergency treatment and of collecting from those accompanying the patient to the hospital whatever data are available as to the motives involved. As has been intimated it is frequently the history secured in the accident ward that guides the staff physician in making his diagnosis of the patient's mental state and in devising effective preventive measures insofar as the self-infliction of further harm is concerned.

Mercury Is Frequently Used

Of course it must be conceded that poisonings are in many instances purely accidental. Moreover, the common tendency of the American people to entrust to their gastro-intestinal canals drugs of unknown origin is responsible in a large measure for the practice of self-dosage that is so common in this country. Due to the beneficent efficiency of pure food laws, however, most proprietary medicines, with the exception perhaps of those containing coal tar derivatives, are relatively harmless unless large amounts are ingested. Whatever the cause of the poisoning, however, the emergency treatment is of course the same in every case and there should be no delay in the institution of remedial measures. It is of interest to remark the frequency with which self-inflicted poisonings occur following the publication in the press of sordid details relating to such a rash act on the part of some prominent person. It appears that Ameri-

cans frequently only need to know of the use of some destructive agent to have a certain type of psychotic person adopt the same measure in his own case.

The well known destructive effects of various preparations of mercury have resulted in the placing of the bichloride salt high in the list of drugs employed to produce self-destruction. Indeed, the common use of certain headache remedies has augmented the number of patients who are brought to the hospital for the treatment of accidental mercury poisoning. The fact that such remedies frequently are found on medicine closet shelves adjacent to a bottle of bichloride tablets renders such a mistake easily possible. An added factor tending to increase the frequency of mercurial poisoning is the fact that of all antiseptic preparations bichloride is most frequently found in the medicine closet of the laity. In addition, this drug is sometimes employed by misguided persons as a contraceptive or as an abortifacient. Because of these facts, in the average hospital receiving ward, almost routinely, remedies are at hand which are necessary in the emergency treatment of this type of poisoning.

Frequently when a patient is rushed to the hospital because of an actual or suspected chemical poisoning there comes with him a history of the nature and amount of the chemical taken and even in some instances thoughtful friends and relatives bring the original container. The physician in the receiving ward having this evidence in his possession may immediately set about his eliminative treatment. The official United States Pharmacopœia bichloride tablet commonly dispensed by pharmacists contains seven and one-half grains, an amount that, incidentally, has also been found to represent the average lethal dose. On the other hand, there is frequently a history of the patient's having ingested many times this quantity and yet recovery has taken place.

A Helpful Safeguard

It is not the purpose of nor would it be appropriate to this article to discuss in detail the symptoms of any of the drug poisonings about to be mentioned. Such information is readily available in most works on therapeutics or toxicology. It is pertinent, however, to remark that death sometimes takes place in as short a period as one-half hour after poisoning, and that the average period in fatal cases elapsing between ingestion and dissolution is seven days. Of course, the severity of the toxicosis depends largely upon the question of whether the drug was immediately rejected by the stomach, whether the chemical antidote was promptly administered and whether the stomach contained food at the time the poison was taken. The United States Pharmacopœia requires that mercuric chloride tablets must be angular in shape, must be colored, blue preferably, must be stamped with the word "poison," with the skull and cross bones plainly in evidence. Such requirements have frequently averted serious accidental poisonings. Attaching these tablets each to the other with a thread has also prevented accidents. When a person thinking he is taking a headache tablet has his attention called to the fact that each tablet is connected to the other with a cord, he is likely to hesitate before swallowing it.

Another Common Poison

In the receiving ward there should be immediately available the whites of eggs, four of which are given in one quart of milk, or if eggs are not available milk alone or milk and flour constitutes the chemical and physiological antidote. A stomach tube should of course be in readiness. It is of the utmost importance to remember that the future safety of the patient may depend wholly upon whether the physician has been sufficiently thoughtful to preserve all stomach washings for examination. To neglect to save the first specimen of urine voided as well as the first stool passed is frequently to overlook the definite possibility of early diagnosis. It may be said that the prognosis is largely favorable or unfavorable in direct proportion to the length of time elapsing between the ingestion of the drug and the beginning of treatment.

After the emergency treatment has been carried out and the patient has been transferred to the hospital ward, the curative treatment has only begun. It now becomes the duty of the drug store of the institution to provide the necessary chemicals for the rather prolonged treatment necessary. Calcium sulphate in fresh preparation, Carter's antidote, sodium hypophosphite, are but three of the preparations in more or less common use. Many others have been advised as chemical antidotes for mercuric chloride, each having its own proponents.

Whichever of these remedies is selected, it is needless to say that there must also be found an alertness and persistence on the part of the physician and nurse in following out day and night the often tedious after treatment ordered. The fact that for the first few days no startling symptoms may be observed and that death most often takes place from kidney insufficiency after at least a week has passed, sometimes accounts for the loss of life because therapeutic efforts are prematurely interrupted. As a practical preventive measure of possible poisoning of patients and of hospital workers who handle this and other lethal drugs, it may

be said that self-dosage by nurses should be rigidly prohibited and that all should look at the label of containers many times before swallowing or giving to others to swallow any type of medication.

Another common drug employed in an attempt at self-destruction is phenol (carbolic acid). This chemical is likewise frequently found in the household medicine cabinet because of its common use as a disinfectant. Its choice as an agent of self-destruction is somewhat increased because the public is rather widely acquainted with its poisonous action. It is said that in the United States the most common cause of suicidal death from poisoning is carbonic oxide (illuminating gas) and that phenol and bichloride of mercury are perhaps second and third in frequency. The odor of phenol is not entirely dissimilar to that of cheap whiskey and accidental poisonings have taken place because of this fact. The receiving ward physician should have but little difficulty in detecting that carbolic acid has been employed in a suicidal attempt because of the rather characteristic burns that are observed on the lips and on the mucous membrane of the mouth and throat. The average fatal dose employed in this country by those who desire to destroy themselves averages about one ounce.

Chemicals Needed for Treatment

It is particularly difficult to lay down any rules whereby such accidental or intentional poisonings may be prevented. Of course the use of concentrated phenol on skin surfaces should be avoided, and the omission by the press of the sordid details concerning poisonings by this agent would be helpful. In the receiving ward the prompt washing with alcohol of tissues that have come in contact with phenol is effective. A 70 per cent solution of alcohol used as a mouth wash may prevent extensive destruction of tissue in this locality. The prompt removal of the poison from the stomach by the use of the gastric tube or requiring the patient to drink large quantities of water are both important measures.

The chemicals necessary in the treatment of this toxicosis in the accident ward are less complicated than those employed by the physician in combating some other poisons. Five per cent sodium bicarbonate solution, Glauber's Salts, alcohol 10 to 30 per cent and water, three to six quarts, are of use in the treatment of phenol poisoning. It has been suggested that when deep ulcerations have resulted from the contact of the stomach and esophageal tissues with this corrosive, the use of the stomach tube might be dangerous. On the other hand, it is most necessary for the accident ward physician to remove promptly as much as possible of the poisonous agent before absorption can take place. Sodium sulphate is sometimes used intravenously in a 1 to 2 per cent solution in amounts of five hundred to one thousand cubic centimeters. Alcohol is thought by many to be a specific chemical antidote for phenol and it is recorded that Dr. S. D. Powell of New York City, in 1899 washed his hands in pure phenol and then likewise in alcohol without any harm to himself. The after treatment of phenol poisoning is largely symptomatic and the physician usually requires that patients remain in bed until all danger of kidney complications has passed.

Arsenic Cases Require Prompt Care

Perhaps of all the drugs employed as homicidal agents arsenic has been most often selected. It is one of the oldest of known poisons and because of its peculiar and insidious harmful action it has been frequently used in the past by professional poisoners to cause death. It has been stated that in 42 per cent of the poisonings by arsenic, homicide was the motive underlying them, while in but 23 per cent and 20 per cent, respectively, was the occurrence suicidal or accidental. The public knows not a little concerning the toxic effect of arsenic and in addition because of the rather common presence of arsenic containing rat poisons and insecticides in the household, this drug is rather easily obtained by those desiring to do harm to themselves.

Because of the common use of arsenic as a spirocheticide, poisonings from this source not infrequently occur. The fatal dose of the arsenic trioxide has been set at from two to five grains, but probably often death has not occurred unless much larger amounts have been taken. Here as in most instances of drug poisoning, the chances of recovery are in direct proportion to the promptness with which emergency treatment is instituted. No receiving ward emergency equipment is complete without the presence of the official United States Pharmacopœia antidote, namely, *ferri hydroxidum cum magnesii oxido*. It should be remarked here, however, that to be effective this remedy must be freshly prepared and its ingredients should be always available in every hospital drug store.

As was true in the case of the poisons previously discussed, the early removal of the drug from the stomach by use of the gastric tube and a thorough lavage of the stomach with soda bicarbonate solution, 2 per cent, is usually effective. If the official antidote is not immediately at hand, milk, albumin water, flaxseed or slippery elm tea in copious amounts should be administered. The emergency closet of the hospital receiving ward should contain these preparations. While not as prompt or as effective perhaps as the gastric tube or the

chemical antidote for use in this poisoning, there should be available in the hospital accident ward such emetics as mustard, zinc sulphate, tartar emetic and apomorphine. The subsequent ward treatment of these patients is more or less symptomatic.

Methyl alcohol is often found by the accident ward physician to be the cause of a toxicosis. The motives, however, involved in methyl alcohol poisoning are rarely suicidal and hence extensive description of the treatment of this type of drug damage will find no place here. The same, however, cannot be said of poisonings by caustic agents such as the alkalies and the acids. They are, however, rather rarely employed for destruction because of the common knowledge of the pain incident to their use. Accidental poisoning from household lye occurs so frequently, particularly in the instance of children, that a definite propaganda has been developed in this country to prevent damage through the careless handling of these agents.

Most Suicides Choose Gas

Illuminating gas (carbon monoxide) is perhaps the commonest agent employed to produce self-destruction. Indeed those who are employed in the accident ward of the hospital need only recall the number of cases of poisoning treated in the course of a year to be convinced of this fact. Because illuminating gas is odorless and because defective heaters are so often found in the ordinary household, the rather frequent occurrence of accidental poisonings by this agent is easily explained. It has been stated that this gas is responsible for more deaths than all other gases combined. Approximately from 65 to 70 per cent of all suicides choose illuminating gas as the facilitating agent of their exit from life. This gas is quickly absorbed by the lining of the lung vesicles and forms as is well known a stable compound with the iron containing element of the blood. This attraction, if it may be so called, between the hemoglobin of the blood and the carbon monoxide gas is 250 times as strong as that which exists between the molecules of oxygen and those of hemoglobin.

As a result, poisoning by illuminating gas may produce symptoms which are rather prolonged and which in effect produce death in the same manner as when air is prevented from reaching the lungs as a result of strangulation. It has been stated that poisoning begins when a concentration of 0.5 per cent in the air is reached and that the outcome is generally fatal when this concentration reaches from 0.2 to 0.4 per cent. A discouraging fact in poisoning with this gas is that several weeks after the acute signs have departed, grave symptoms may develop which are due to damage to the central nervous system. Insofar as the preparation is concerned for the reception of this type of case in the hospital accident ward it may be said that methods for the efficient administration of oxygen seem to be of first importance. The United States Bureau of Mines suggests the constant availability of oxygen tanks to which from 5 to 8 per cent of carbon dioxide has been added. Suitable masks for use in administering this mixture should of course be at hand.

Ambulances Need Oxygen Equipment

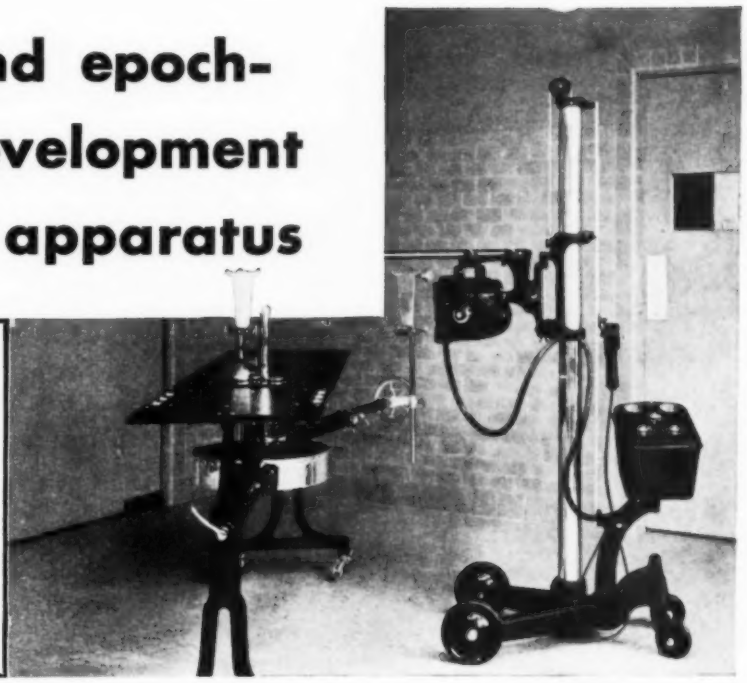
A prompt removal of the patient from the toxic atmosphere is of greater importance in poisoning by gas than perhaps is the rapid institution of treatment in the case of toxic drugs which have been ingested by mouth. Every hospital ambulance should be equipped at all times with oxygen. It has been said if some response is not observed following the first hour of treatment in the case of complete unconsciousness from the inhalation of illuminating gas that some definite injury to nerve tissue has taken place. The recovery or death of the patient is ofttimes determined during the first sixty minutes of treatment.

The development of the respirator has given to hospitals generally an added and useful implement in combating poisoning by gas. It may be said here, however, that rarely does so intensive an effect upon the respiratory center occur that voluntary efforts at respiration are not made. This is not the case in acute morphine poisoning since in such instances all voluntary efforts to breath are apt to cease. The respiratory movements, however, may be shallow and the added depth of respiration brought about by the use of this machine probably increases the interchange of carbon monoxide and oxygen and hence lightens the degree of poisoning. Most respirators are so equipped that oxygen and carbon dioxide may be alternately administered. If this is not the case the administration of the ordinary 95 per cent oxygen and 5 per cent carbon dioxide mixture with the use of a mask while the patient is still in the respirator has been found helpful.

To those who have observed a patient poisoned with carbon monoxide the cherry red appearance of the skin is significant. In answering the queries of frantic relatives as to the possibility of recovery, most accident physicians are acquainted with the fact that if a 0.2 per cent concentration of this gas has been inhaled for four or five hours or a 0.4 per cent for one hour, recovery can hardly be expected.

This is the first of a series of articles dealing with various types of hospital emergencies. Next month the treatment and handling of the delirious and the psychotic will be discussed.

A new and epoch-making development in fracture apparatus



Utilization of Victor Oil-Immersed Shock Proof X-Ray Unit in Dr. Hawley's New Orthopedic Table solves problems of long standing.

WHEN Dr. Hawley decided to redesign his original orthopedic table, he was determined to find a practical solution to the problem of incorporating x-ray apparatus for making radiographs in cases of fracture, and for reducing fractures under the fluoroscope—without the necessity of transferring the patient from the table.

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Consider the advantage in being able to quickly bring this model "D" Mobile Shock Proof Unit into position alongside the new Hawley Table, for radiography of the fracture from above or from the side, or in swinging the tube head below for the purpose of fluoroscoping the fracture during reduction. Neither the surgeon nor his assistant need concern himself about the close proximity of the x-ray tube to the field of operation, as this revolutionary design in x-ray apparatus provides 100% electrical safety.

Another distinct feature in the Model "D" Unit is its mobility. Although an important adjunct to the new Hawley table, it may be used as a utility unit in any other part of the hospital, for bedside x-ray diagnosis in rooms and wards, as well as in the operating room. A complete, self-contained x-ray plant, immediately energized by simply plugging in to the nearest electric convenience outlet.

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Maintenance, Operation and Equipment:

Ten Ways of Saving Thousands of Dollars

By ADA BELLE McCLEERY
Superintendent, Evanston Hospital, Evanston, Ill., and
HERMAN SMITH, M.D.
Superintendent, Michael Reese Hospital, Chicago

SINCE this is the season in which budgets are being compiled for the coming year, every hospital superintendent is confronted with an acute problem demanding an immediate and a satisfactory solution.

The problem probably would be less difficult if a shorter view were taken and a budget made for each quarter instead of one budget for a twelve-month period. However, the length of the period does not alter the necessity of basing both the estimated income and the estimated expense upon probabilities rather than upon possibilities. Conservatism in this respect brings its own reward as it lessens the danger of a deficit later.

A budget cannot be balanced unless the probable income equals the probable outgo. Since overestimation of expected income is economically unsound, all expense must be scrutinized carefully in order that the budget may have practical value.

In approaching a study of a department it is well to consider anew its purpose. Is the end for which the department was established being realized? If not, could the department be abolished? What adjustments are necessary to make it function as it should? Is such an expense justified? If the decision is to continue the department equipment, personnel and materials should in turn be subjected to research methods in order that all unnecessary expense may be eliminated.

"Why This?" "Why That?"

The so-called major operations of the organization, such as food service, power plant, laundry and the ever present pay roll are not likely to be overlooked.

A place of considerable importance so far as expense is concerned, but one frequently overlooked or given scant consideration from this aspect, is the ward unit or private division where patients are actually treated. This section is always uppermost in mind whenever the care of the patient is concerned, but there are so many different factors and groups involved in the proper or improper utilization of supplies in this division that it is perhaps unconsciously avoided.

A rough tabulation of the cost of supplies used directly on these units will show that about 7 per cent of the total expenses, including salaries and supplies, or 19 per cent of the expenses for supplies alone, or 40 per cent of the expenses for supplies after food and fuel have been deducted, are used on these units.

The approach to the problem is by repeated objective observation of all ward technique, with the quizzical attitude of "Why this?" "Why that?" This attitude should be one that does not merely desire to replace the present with something different, but to replace the present with something more simple.

Newspapers Used to Wrap Gloves

The following are a few examples of economies that have actually been made. While of course not all of these are applicable to every hospital, they do show a few of the possibilities.

Hand towels—In order that medical asepsis might be observed, a pile of hand towels was kept on a table near each isolated patient. A towel was used once and discarded. As an economy measure, the size of the towel was reduced from twelve to nine inches, with a saving of 25 per cent. In other words 100 additional towels were made from each 100 yards of material.

Infant gowns—Formerly gowns were made a yard and a quarter long from material forty-five inches wide. Under the new specifications the gowns were made one yard long from material thirty-six inches wide. The saving was 26 per cent.

Glove wrappers—A fifteen-inch cotton square was used for wrapping gloves for sterilization. Newspapers were substituted at a saving of 100 per cent.

Forceps jar antiseptic solution—Sixty per cent alcohol had always been used for the immersion and the storage of sterile forceps for picking up sterile instruments and dressings. Bacteriologic study showed that a 1-5000 solution of potassium mercuric iodide was equally efficacious. While this solution is slightly corrosive to the forceps, the cost of nickel plating the instruments is only a fraction of the difference in cost between alcohol and the potassium mercuric iodide solution. The saving amounted to 90 per cent.

Alcohol Dispenser Eliminates Waste

Solution of green soap—A thorough study of all uses of green soap showed that it was used to wash and scrub the hands, to clean feeding nipples, to soak instruments, to soak rubber gloves, for surgical preparation of the skin and for other purposes. It was found that solutions of green soap could be dispensed with, and ordinary white hand soap, or the cheaper kitchen soaps used for all purposes except vaginal preparations in the operating and the obstetric departments. A solution of green soap was then supplied to these two departments on the basis of two ounces for each preparation. The saving resulting from these changes amounted to 80 per cent.

Back-rub alcohol—A study of the end results of the care of patients' backs with varying strengths of alcohol solutions showed that a 15 per cent alcohol solution was as effective as the 60 per cent solution formerly used. The saving was 75 per cent.

Alcohol—A study of all the external uses of alcohol throughout the hospital showed that in the operating rooms alcohol was used for hand sterilization as the final step after scrubbing with soap. Formerly, a solution of 60 per cent alcohol was placed in large wash basins for this purpose. Now, an alcohol dispenser is in use, built somewhat on the basis of a soap dispenser wherein the alcohol, after being squirted on the surgeons' hands, is collected through a funnel into a waste alcohol bottle. This waste alcohol is found to be sterile even after long use. It is raised to 60 per cent strength by the druggist and reissued. Only the alcohol that splashes over the funnel is wasted. Alcohol of 60 per cent strength was likewise used for the storage of suture material tubes in the operating room. Now potassium mercuric iodide, 1-5000 solution, is used for this purpose. The waste alcohol from the surgeons' scrub basins was used to clean surgical instruments. With the introduction of alcohol dispensers, no waste alcohol is available, because the drug department collects the waste alcohol and replenishes the dispenser with fresh alcohol. Ordinary soap solution is now used to clean instruments. Sixty per cent alcohol is now supplied to the operating rooms only for skin preparation as part of the tincture of iodine technique on the basis of one and one-half ounces for each operation. The saving amounts to 80 per cent.

Mouth wash—It was found that a mouth wash was being purchased for routine mouth hygiene. While this mouth wash was cheaper than the proprietary types, it was, nevertheless, an extravagance. A simple mouth wash was made up in the hospital drug room consisting of a combination of the Dobell's and the antiseptic solution types, which was as satisfactory as the purchased product. The saving in cost amounted to approximately 80 per cent.

A study of the use of surgical and utility glassware showed that economy would result from substituting metal for glass items when possible, such as enamel ware in place of glass urinals, and noncorrosive metal or copper boxes in place of glass containers for sterile surgical supplies.

Medicine cabinets and the solutions used in the utility and the dressing rooms in the various divisions were studied, and all drugs that were used infrequently or could be eliminated entirely were removed. Only those drugs necessary for efficiency were kept. The time taken by nurses in having stock bottles refilled was held important in considering efficiency. Experience has shown that more economy is practiced when smaller quantities of solutions are available than when there are large quantities of a solution on hand.

Administrator Will Be Repaid

The savings made by considering the above suggestions have been more or less substantial in certain organizations. Irrespective of the actual amount saved, the administrator who studies these matters will be more than repaid for his time and effort by the increased knowledge obtained of the intimate workings of his organization. It is obvious that many varied items and techniques will come under consideration in the different types of organizations represented throughout the country. The outstanding assets to the administrator will be a more detailed and more exact evaluation of the intelligence and the sincerity of purpose of all those actually working with the patients, and a better knowledge of the care the patient is actually receiving. The latter not only should be, but almost invariably is, the keystone of the hospital. No time or effort spent observing and evaluating this highly important factor of patient care can be considered wasted by the hospital superintendent who is anxious to improve the efficiency of his institution.

These times demand ability, experience and responsibility as great as this

Above: Ideal wheeled stretcher —extremely light, rigid. Litter 1½" deep. Note handy blanket shelf.

Left: Ideal electric serving table (waterless). No installation expense.

Below: Ideal all-purpose operating table. All principal positions. Low priced.

Below: Ideal oxygen tank truck. Better balance, easier handling.

NOW, especially, when every penny counts, is not the time to experiment with hospital equipment. Ideal equipment, food conveyors, trucks, operating tables are the products of engineering ability, long, practical experience and the co-operation of hospital authorities. They carry the guarantee of a well-established and financially sound manufacturer.

Below: Ideal tray carrier. Designed to minimize dish rattling.

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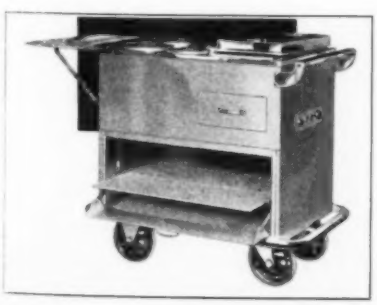

Left: Medium size indoor Ideal conveyor, enclosed type. Ideal conveyors are made in sizes and styles to fill the food distribution needs of any kind of hospital or institution. Keep food hot and appetizing. Eliminate mealtime noise and confusion. Cut food service costs.

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When Hospital Silverware Needs Attention

By RAYMOND P. SLOAN
New York City

Proper maintenance of silverware is daily becoming a serious problem in hospitals faced with diminishing funds for servicing old equipment or purchasing new. It involves the question of how much should be spent on repairing old plated silverware and how this may best be accomplished.

Nickel silver is universally used as the base metal for plated ware. Formerly known as German silver this is composed primarily of copper, nickel and zinc, the quality being governed by the amount of nickel in the mixture. Hence 18 per cent nickel silver which is used generally for hollow ware and flatware is composed of 18 per cent nickel, 68 per cent copper and 14 per cent zinc. This is immersed in a plating bath where a uniform amount of pure silver is deposited upon the article to be plated.

Local Repair Men Not Dependable

To do a good job in repairing flatware means that the silver plating must first be removed, the pieces properly cleaned and polished and then replated and refinished. When it is considered that from 60 to 70 per cent of the cost represents a labor charge it is evident that in the case of flatware a good repair job costs almost as much as new merchandise.

The bigger the institution, obviously the more serious the problem due to the larger stocks handled and the attendant difficulties of proper supervision. Careless treatment too frequently makes necessary repairs and replating that might otherwise be postponed several years. Strong cleansing chemicals, for example, have been known to eat into silver plate that otherwise would have been good for twenty years.

The temptation too often is yielded to to save time and cut expense by turning over the work to local repair men, instead of packing up pieces that need refinishing or repairing and sending them back to the manufacturer from whom they were originally purchased. Such action may save time, but it generally proves costly. In fact, unless the repair shop in question is unusually reliable trouble follows such a procedure for the object is to get the cash and to assume no responsibility for how the merchandise wears.

Many times such shops in replating flatware plate only sufficiently to cover up obvious defects. Then, too, instead of removing dents in hollow ware by working from the inside they are merely ground which causes a thinning of the base metal. It frequently happens that pieces are ground so thin that a fall on a hard surface renders them useless.

Another trick the unscrupulous repair man has been known to perpetrate is to fill in dents with soft solder which is nothing more than lead, and then replate over it. It is practically impossible for anyone to detect this when the merchandise is delivered. More easily discovered, perhaps, is the substitution of plain wood for wood fiber or other special material which may be used to insulate the handles of coffeepots or teapots.

There is another reason why the manufacturer is the logical one to whom to turn for repairs. He furnishes the original parts, such as hinges and pins, which may need replacing. The local repair man, on the other hand, may substitute some other, if he cannot get hold of the original part.

If he does supply the original part it usually costs the customer more. Take, for example, the hinge of a coffeepot which the manufacturer estimates costs him about 25 cents. He is not going to sell it to the repair man at the cost price. Nor is the repair man going to turn it over without adding a few cents to it.

The problem, therefore, may be worked out most satisfactorily by making periodic examinations of the silverware, both flat and hollow ware, sorting out the pieces that need repairing or refinishing and returning them to the manufacturer. Because the merchandise bears his name he will see that it is honestly rejuvenated.

Homemade *Versus* Ready-Made Ice Cream—Comparative Costs

By C. P. WRIGHT, JR.
Intern in Hospital Administration, Grasslands Hospital, Valhalla, N. Y.

Most hospitals, it is believed, manufacture their own ice cream. In the past, there has apparently been little doubt but that any institution of size could produce ice cream for less than a product of equal excellence could be purchased. Recently, however, due to the decline in the cost of milk and other materials used in ice cream manufacture, and due perhaps to a general slack in business, certain manufacturers have made overtures to hospitals for their ice cream business with the statement that if all costs were carefully computed, the hospitals would find it advantageous to purchase ice cream ready-made.

With these considerations as a basis a study was made to determine the facts concerning the cost

of manufacturing ice cream at the hospital. A firm was asked for a quotation, and set what appeared to be an economical figure for a good quality of ice cream. The study then proceeded. The accompanying table summarizes the study.

From the table, it may be concluded that it is cheaper to manufacture ice cream at the hospital than it would be to purchase it from the firm from which the quotation was obtained. The home-made product, then, has such advantages as (1) lower cost, (2) no danger of prices being raised after arrangements have been made to buy ice cream, (3) absolute knowledge of ingredients of the ice cream and (4) flexibility of ice cream butter fat content to meet the actual needs of hospital diet.

HOSPITAL'S COST FOR AN 80-QUART MIXTURE, 12 PER CENT BUTTER FAT ICE CREAM

Ingredients	*Amounts*	*Butter Fat*	*Unit Cost*	*Total Cost*
Milk	28 qts.	3.5	$.07	$1.96
Condensed Milk	30 qts.	9.	.22	6.60
Cream	12 qts.	40.	.65	7.80
Eggs	10 doz.		.33	3.30
Sugar	12 lbs.		.05	.60
Flavoring	1 qt.		.50	.50
Cost of Ingredients				$20.76

Freezing Costs	*Amount*	*Unit Cost*	*Total Cost*
Salt	100 lbs.	$.01	$1.00
Ice	600 lbs.	.005	3.00
Electric Power			1.00
Labor	1¾ hrs.	.40	.70
Cost of Freezing			$ 5.70
Total Cost of Manufacturing			$26.46

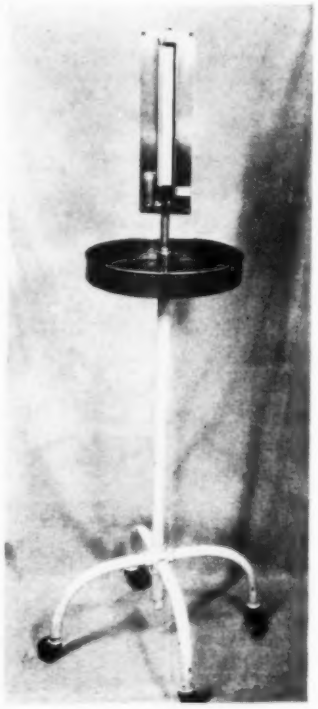
80-qt. mixture plus 28.6 per cent (expansion) = 102.88 qts. ice cream
Cost of 102.88 qts. $26.46
Cost per qt. ..... .257
Cost per gal. ..... 1.028—hospital manufacture
Lowest quotation per gal. ..... 1.10 —commercial manufacture

A Combination Manometer and Anesthesia Tray

By NORBERT A. WILHELM, M.D.
Assistant Superintendent, Peter Bent Brigham Hospital, Boston

In keeping with the general effort to reduce expenditures, we recently became interested in replacing our air manometers with mercury for use in the operating room. A comparison of figures for the previous year satisfied us that there was a marked difference in the cost of upkeep between these two sphygmomanometers and that it would be decidedly to our advantage to use mercury machines.

A manufacturer was offering at the time a mercury manometer placed on a stand. Our instrument is a modification of this and we believe it is a definite improvement. The machine is 54 inches high and the manometer can be raised or lowered according to the needs of the anesthetist. It is held in position by a thumbscrew. A small coiled spring was placed in the bottom of the stand to absorb the shock and to prevent breakage if the manometer were suddenly released. The main support is standard three-quarter inch pipe and the rod supporting the manometer is one-half inch in diameter and is nickel plated. The four legs and a central piece were filled with lead, which lowers the center of gravity so that danger of tipping over is eliminated. One of the best ball bearing casters obtainable was used which assures smooth, quiet and easy moving from one room to another. These casters do not slide and they respond to the slightest effort.

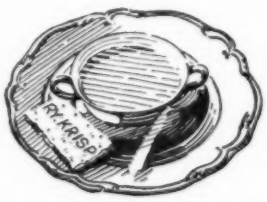


This picture shows the combination manometer and anesthesia tray which is being used at Peter Bent Brigham Hospital. Each of the hospital's operating rooms has been equipped with one of these machines, which were made in the institution's own shop.

The tray proved to be a welcome addition for it did away with the anesthesia tray. It is 14 inches in diameter, 2 inches deep and is made of rustproof metal. We have divided this tray into three compartments, which separate the ether cans, emesis basin, tongue forceps and other instruments.

We were so pleased with the results obtained from the original instrument that we have equipped each of our operating rooms with one of these machines. The machines were made in our own shop and the manometer used was the so-called wall type.

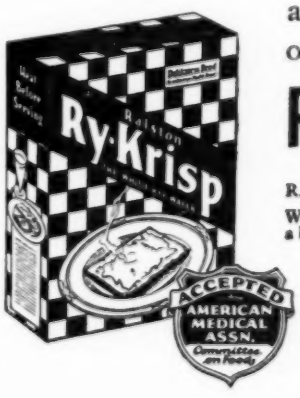
"I'm glad you said Ry-Krisp, Doctor —It tastes so good"



YOU who direct diets need no introduction to the fact that patients will adhere more carefully to a diet which includes palatable foods. Because "it tastes so good" Ry-Krisp is found to be highly acceptable in many restricted diets.

There's a tempting crispness—a distinctive flavor to Ry-Krisp Whole Rye Wafers which makes them welcome at every meal — with as wide a variety of foods as the specific diet permits.

Ry-Krisp is made of flaked whole rye, water and a dash of salt — double-baked to insure lasting crispness. That's all—yet the very simplicity of its composition makes Ry-Krisp not only acceptable but highly valuable as a safe, wholesome food — (a) for patients allergic to wheat, milk or eggs, (b) in diets planned to assist laxation, or (c) for moderately restricted carbohydrate diets.



Our Laboratory Research Report on Ry-Krisp Whole Rye Wafers and the booklet Special Recipes, Menus and Food Lists for wheat, egg and milk-free diets will be of material assistance to you in planning special diets. These will be forwarded to you at once without cost. Just fill in the coupon or attach it to your letterhead.

Ry-Krisp *Whole Rye Wafers*

RALSTON PURINA COMPANY, 531 Checkerboard Square, St. Louis, Mo.

Without obligation, please send me your Laboratory Research Report on Ry-Krisp, a booklet of special recipes, and a supply for testing.

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Address.....

City.....

This offer limited to residents of the United States and Canada

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

A Hospital Kitchen That Does Double Duty

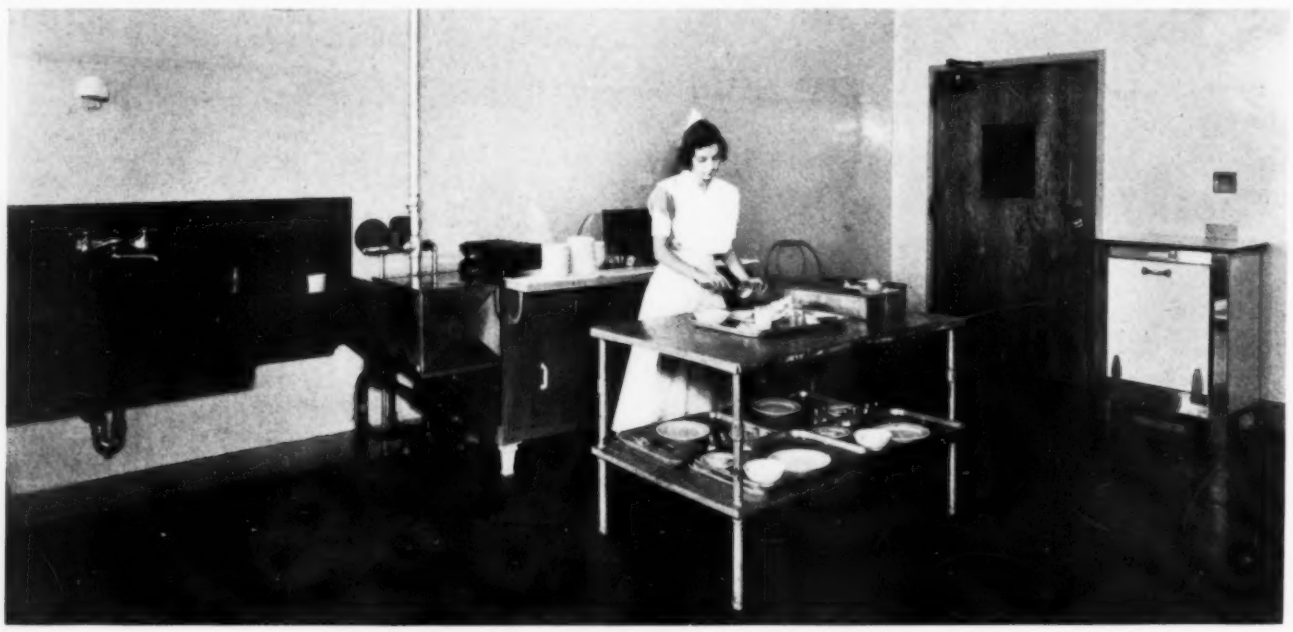
By EUGENIA MARTIN SHRADER
Formerly Dietitian in Chief, Barnes Hospital, St. Louis

THE dietary department of Barnes Hospital has a somewhat different problem to cope with from that met in most dietary departments in this type of hospital. Barnes is the largest in a group of hospitals affiliated with Washington University. Each of these hospitals has its own kitchen which provides food only for its patients and employees. The dietary department at Barnes Hospital, where the facilities are greater, supplies food for the doctors and nurses from the adjacent hospitals.

It is a more difficult problem to provide food for those outside one's family than for the family alone, especially when there is a charge attached. More than average care is required under these conditions in the arrangement of menus and in the preparation of food in order to keep everyone as content as possible.

The daily per capita cost of a dietary department such as that at Barnes is high. Ordinarily the daily per capita cost for a hospital with a predominance of ward and semiprivate patients can be kept fairly low, but it is a most difficult task where 66 2/3 per cent of those served are members of the personnel.

The dietary staff at Barnes consists of a chief dietitian and four assistants, including an administrative dietitian, a teaching dietitian, a thera-

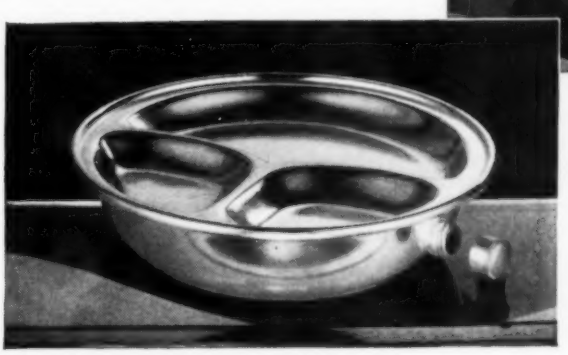


Each ward diet kitchen has a steam table and a refrigerator for preserving the special diet cups prepared in the private pavilion kitchen. The nurse is preparing special trays in a typical ward diet kitchen.

NEW The Famous Gorham Hot Water Plate with an EXTRA DEEP WELL

. . . and a new three-compartment Hot Water Plate

A GORHAM hot water plate is now being made with an extra deep well. . . .And Gorham has added a three-compartment plate (also with deep well) to its line. These plates are easily filled and easily cared for. Following is a partial list of hospitals which use Gorham hot water plates:



Above is the new hot water plate 8½ inches in diameter. Cover to fit, 8 in. in diameter.

LEFT is the inside view of the new three-compartment plate. (Size as above.)

No soft metal or soft solder is used in the construction of Gorham hospital silverware.

Alameda, Calif.
Alameda Sanatorium
Berkeley, Calif.
Alta Bates Hospital
Buffalo, N. Y.
Children's Hospital
Clearfield, Pa.
Clearfield Hospital
Durham, N. C.
Watts Hospital
Haywood, Calif.
Haywood Central Hospital
La Jolla, Calif.
Scripps Metabolic Clinic
Los Angeles, Calif.
Kaspar Cohn Hospital
St. John's Hospital
Milwaukee, Ore.
Portland Open Air Sanatorium
Morristown, N. J.
All Souls Hospital
New York, N. Y.
French Hospital
Hunts Point Hospital
Neurological Institute
Oakland, Calif.
East Oakland Hospital
Providence Hospital
Pasadena, Calif.
Pasadena Hospital
Phoenix, Ariz.
St. Joseph's Hospital
Pittsburgh, Pa.
Allegheny General Hospital
Portland, Ore.
Dr. R. C. Coffee Clinic & Hospital
St. Vincent's Hospital
Riverton, Wash.
Riverton Sanatorium
Sacramento, Calif.
Mater Misericordiae Hospital
Sutter Hospital
San Francisco, Calif.
Children's Hospital
Mount Zion Hospital
St. Francis Hospital
San Francisco, Calif. (continued)
St. Joseph's Hospital
St. Luke's Hospital
San Luis Obispo, Calif.
San Luis Obispo County General Hospital
San Mateo, Calif.
Mills Memorial Hospital
Santa Barbara, Calif.
Santa Barbara Cottage Hospital
Seattle, Wash.
Swedish Hospital
Stamford, Conn.
Stamford Hospital
Woodland, Calif.
Woodland Clinic

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peutic dietitian, who also has charge of the food that is served to the patients in the private pavilion, and a dietitian in charge of the department of metabolism.

Selective Menus Are Used

The greater part of the department is housed in what is known as the service building which is connected to the main building by a basement hallway. The main kitchen and pastry kitchen occupy half of the ground floor. The scullery department and dining rooms for white and colored employees occupy the other half of the ground floor. Dining rooms also take up all the first floor space and half of the second floor. The rest of the space is used for dormitories.

Food is sent from the main kitchen to the wards in insulated carts and to the dining rooms by elevators. The semiprivate patients are served from the ward diet kitchens. Additions are made, however, to the general ward diet for the semiprivate patients.

The private pavilion kitchen is located directly underneath the private pavilion section which is at another end of the building. Food is prepared here for the private patients, for all nurses ill in the infirmary and the nurses' residence and for all special diets other than the calculated ones prepared in the metabolic department. The food is sent to the various floors in separate containers where it is placed in a steam table or an ice box as the case may be.

Selective menus are used on the private pavilion, and the patients are also allowed to scratch the menu and add another article that they may desire. This may sound like an expensive measure but the satisfaction to the patients far surpasses the added cost. It does, however, take the greater part of the time of one cook in the kitchen to prepare the special orders for the patients on the private pavilion.

Each special diet that is sent from the private pavilion kitchen to the wards is placed in a separate box with a menu enclosed. These boxes are carried to the various wards in the carts from the main kitchen. Each ward diet kitchen is fitted with a steam table that has pans with round holes cut into them into which the diet cups fit and are heated. These are heated piping hot and are ready for the patient by the time the diet nurse has finished serving the regular diets to the patients in the wards.

A section of the nurses' dining room at Barnes Hospital, showing the steam tables, the menu board and part of the dining tables. Electric fans help keep the air in the room fresh.

Physical Examination Given Employees

The metabolic department is ideally located in the center of the building on the second floor. This division has a kitchen and two wards of eight beds each for men and women. The tray is carried di-

This picture illustrates the type of food conveyor service used on the semiprivate wards in Barnes Hospital. The semiprivate patients are served from the ward diet kitchens.

rectly from the kitchen to the patient by the nurse or student dietitian who has prepared it.

The sixty employees of the dietary department, all of whom are white, and chiefly women, are given a physical examination upon entrance. Their names are not permanently entered on the pay roll until it is certain that they are physically fit for the work. Women employees, in addition to salary, are given room, board and uniforms. The men are given board and uniforms, only.

All staples, fresh fruits and vegetables are purchased by the buyer after a consultation with the dietitian. Orders for practically all canned fruits and vegetables are placed in the fall.

Teaching Course Is Offered

All requisitions for food from the various divisions to the storeroom are priced by the buyer and sent to the dietary office each week where the daily per capita cost is figured.

The dietary department at Barnes Hospital with the assistance of the formula room and the metabolic department of the Children's Hospital and the food clinic of Washington University Dispensary, offers an eight months' course for students of dietetics who have their degrees, with a major in foods and nutrition. Since this is a teaching center for nurses and medical students, the facilities also lend themselves favorably to the teaching of student dietitians.

Nursing Care Should Not Be Based on Patient's Pocketbook

To teach for use in private rooms a different nursing technique from that which is used in wards leads to poor quality nursing, in the opinion of Adda Eldredge, director, Wisconsin Bureau of Nursing Education, who read a paper at the nursing section of the American Hospital Association convention in Detroit.

"Bathing the ward patient in one basin of water while specifying that the private patient should have the water changed 'twice' and other differences founded not on needs but price will, even with the best nurse, tend to make distinctions in nursing care a matter of pocketbook, not need, decency or art," says Miss Eldredge.

The new importance of

PINEAPPLE-CANNED

Now shown to possess more known dietetic values than any other fruit

NO wonder this famous fruit has long been a favorite with patients. They like its delightful flavor, color, its appetite appeal.

Now there are many additional reasons why it should be served frequently.

Recent food research shows that it possesses more known dietetic values than any other fruit. Findings based upon soundly established tests on human subjects.

1. **Canned Pineapple is a generous source of vitamins A, B and C.**
2. **It furnishes the minerals that safeguard against nutritional anemia—iron, copper and manganese. And it supplies notable amounts of calcium and phosphorus.**
3. **It helps effectively to prevent acidosis by contributing to the normal alkalinity of the blood.**
4. **Canned Pineapple speeds digestion in the stomach of foods with which it is eaten.**
5. **It stimulates renal function, increasing the elimination of nitrogenous waste products.**

Combined, all these essential values in Canned Pineapple justify not only its frequent use in the hospital. They also warrant its appearance on unrestricted diets—as well as some special diets—*at least once a day.*

Serve Canned Pineapple in portions of two slices, or as a Pineapple Cup prepared with crushed or tidbits.

(These statements are made only about Canned Pineapple, NOT raw pineapple. The temperatures applied in canning cause a beneficial change of dietetic importance.)

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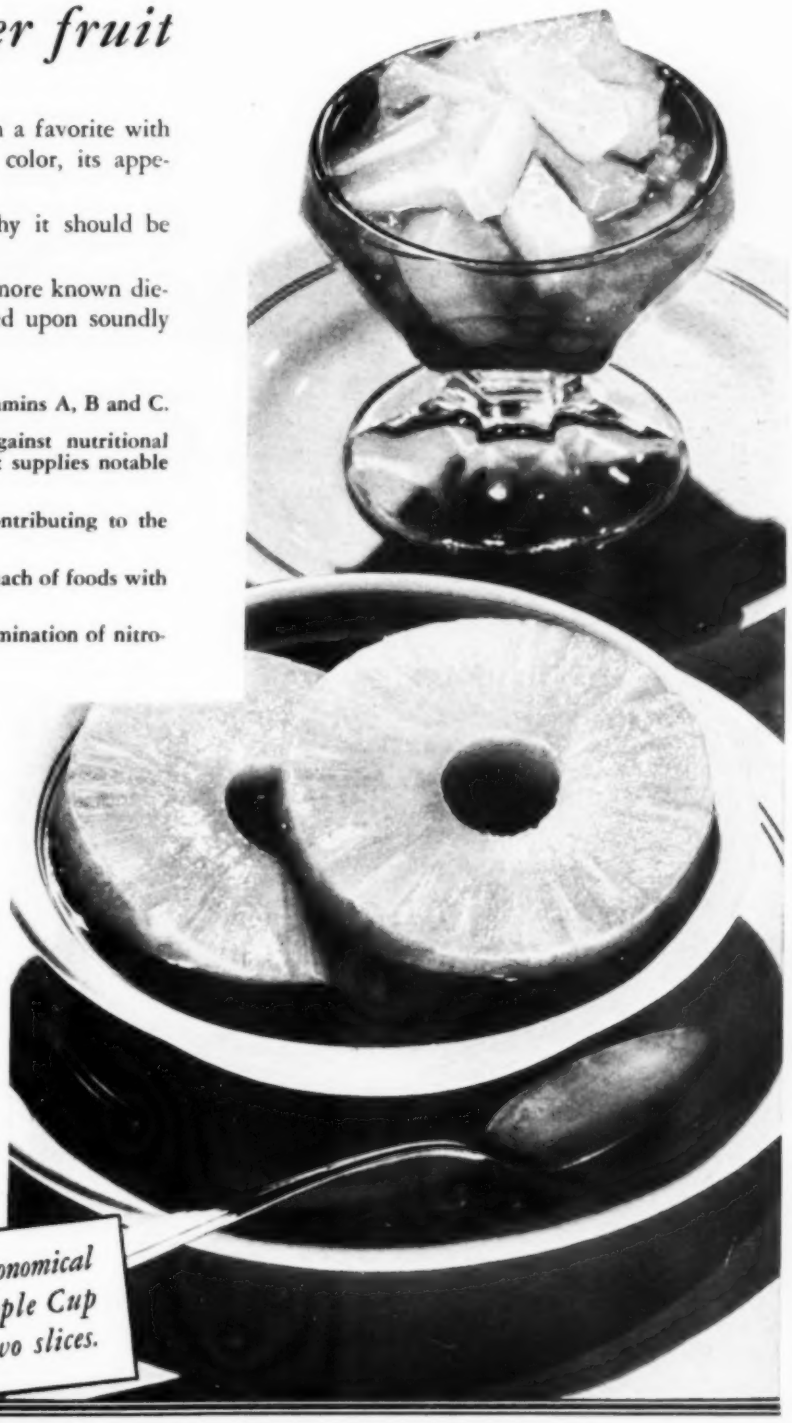


Quick, easy to prepare, and economical for hospital use. A Pineapple Cup of crushed or tidbits. Or two slices.

NEWS OF THE MONTH

Medical Care Costs Committee Holds Final Conference

The New York Academy of Medicine housed an all-day conference on November 29, the final meeting of the Committee on the Costs of Medical Care, which, besides some of its own members, brought together about 150 persons of prominence in the world of medicine, dentistry, hospital service, public health, business, nursing and social work. The final report of the committee, which was reviewed in the December issue of THE MODERN HOSPITAL, was formally released to the public on that day. President Hoover sent a letter to the committee commending its work and Dr. Thomas Parran, Jr., commissioner of health of New York State, read at the opening session a letter from President-Elect Roosevelt.

During the morning, the conferees were divided into six groups, each of which had the opportunity of hearing brief addresses from six speakers, some of whom were members of the committee and others members of its research staff. They presented the chief findings of the committee's studies and there were opportunities for some questioning and discussion after each address.

Plan to Continue Work

At the luncheon and the dinner sessions, Dr. Ray Lyman Wilbur, chairman of the committee and Dr. C.-E. A. Winslow, vice chairman, presented the high points resulting from the five years' work of the committee. Dr. J. A. Hartwell, president, New York Academy of Medicine, discussed "The New Outlook for Medicine"; James R. Angell, president, Yale University, gave an entertaining address on the future of public health. Livingston Farrand, president, Cornell University, spoke of the present and future significance of the committee's findings and recommendations from the public health point of view, while Dr. Llewellys F. Barker, Baltimore, and Dr. Nathan B. VanEtten, New York City, discussed the same subject from the point of view of physicians representing the majority and minority reports, respectively.

Towards the close of this notable gathering, it was explained by Doctor Wilbur that the committee now goes out of existence, but that officers of several foundations which had contributed to its work had expressed interest in supporting efforts which would carry forward some of the main recommendations made by the committee. It was announced that conferences were under way to prepare some plan which might lead to a national organization for this purpose.

Hospitals were well represented at the conference by such men as Dr. W. L. Babcock, Grace Hospital, Detroit; Dr. A. C. Bachmeyer, Cincinnati General Hospital, Cincinnati; F. O. Bates, Roper Hospital, Charleston, S. C.; Dr. R. H. Bishop, Jr., University Hospitals of Cleveland, Cleveland; Alfred T. Carton, Chicago; Dr. E. H. L. Corwin, New York City; Michael M. Davis, Julius Rosenwald Fund, Chicago; Dr. N. W. Faxon, Strong Memorial Hospital, Rochester, N. Y.; Paul Fesler, Wesley Memorial Hospital, Chicago; Arthur A. Fleisher, Philadelphia; Dr. S. S. Goldwater, New York City; Dr. George O'Hanlon, Jersey City Medical Center, Jersey City, N. J.; Robert W. Irwin, Grand Rapids, Mich.; Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y.; Dr. Willis G. Nealley, Brooklyn Hospital, Brooklyn, N. Y.; Dr. C. G. Parnall, Rochester General Hospital, Rochester, N. Y.; Dr. Henry M. Pollock, Massachusetts Memorial Hospital, Boston; Dr. W. S. Rankin, Duke Foundation, Charlotte, N. C.; Dr. Lewis A. Sexton, Hartford Hospital, Hartford, Conn.; Dr. Donald C. Smelzer, Graduate Hospital of the University of Pennsylvania, Philadelphia; John M. Smith, Hahnemann Medical College and Hospital, Philadelphia; Dr. Frederic A. Washburn, Massachusetts General Hospital, Boston, and Dr. O. F. Ball, Chicago.

Methodist Group Will Meet in Indianapolis

The annual meeting of the National Methodist Association of Hospitals, Homes and Deaconess Work will be held on February 15 and 16, at Indianapolis, at the Claypool Hotel.

The hospital division meetings will be under the supervision of Paul Fesler, superintendent, Wesley Memorial Hospital, Chicago. The deaconess work division will have as its chairman Alice Thatcher, formerly of Christ Hospital, Cincinnati. Group conferences will feature the program.

Rev. John G. Benson, superintendent, Methodist Hospital, Indianapolis, is president of the group.

NEWS OF THE MONTH (Cont'd)

A. H. A. Forms Council to Study Medical Cost Report

The American Hospital Association has appointed a council on community relations and administrative practice which will undertake an immediate study of the recommendations of the Committee on the Costs of Medical Care calling for changes in existing relations between hospitals, the medical profession and the public.

Announcement of the formation of the council was made early in December by Dr. S. S. Goldwater, New York City, a trustee of Mt. Sinai Hospital, New York City, who is chairman of the new group. Other members are: Dr. G. Harvey Agnew, hospital division, Canadian Medical Association, Toronto, Ont., Dr. B. W. Black, Highland Hospital, Oakland, Calif., Dr. R. C. Buerki, State of Wisconsin General Hospital, Madison, Wis., Michael M. Davis, Julius Rosenwald Fund, Chicago, Dr. Joseph C. Doane, Jewish Hospital, Philadelphia, Rev. Maurice F. Griffin, Cleveland, Dr. A. K. Haywood, Vancouver General Hospital, Vancouver, B. C., Mary I. Hicks, Norton Memorial Infirmary, Louisville, Ky., Dr. Basil C. MacLean, Touro Infirmary, New Orleans, Ada Belle McCleery, Evanston Hospital, Evanston, Ill., Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y., Dr. W. S. Rankin, Duke Endowment, Charlotte, N. C., Dr. Winford H. Smith, Johns Hopkins Hospital, Baltimore, Dr. Frederic A. Washburn, Massachusetts General Hospital, Boston.

Eye Clinic of New Type Is Opened in New York City

A clinic to be devoted to cases of improper neuromuscular control of the eyes with resultant cross-eyes and industrial blindness, the first clinic of its kind in this country, was opened recently at Fifth Avenue Hospital, New York City. Treatments in this clinic will be limited to corrective exercises and surgery will not be resorted to.

The exercises will be given by means of instruments recently developed by eye specialists and physicists. Some of the apparatus to be used will be the first of its type in this country. The clinic will be modelled after the first of this kind established at the Royal Westminster Eye Hospital, London, England, through the influence of Dr. Ernest Maddox.

Dr. Le Grand Hardy, director, eye department, Fifth Avenue Hospital, will be in charge of the clinic. He will be assisted by a group of eye specialists, neurologists, psychiatrists and a special research worker, Elizabeth Stark. Miss Stark recently returned from London where she was sent to study the methods used at Doctor Maddox's clinic.

Nursing Group Will Meet in Chicago, February 14

The Central Council for Nursing Education, Chicago, will hold a luncheon meeting on Tuesday, February 14, at the Palmer House, immediately following the joint session, devoted to nursing, of the Council on Medical Education and Hospitals of the American Medical Association and the American Conference on Hospital Service.

Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, will speak on "Future Trends in Nursing."

Function of Librarians' Registry Is Explained

The registry for record librarians established by the Association of Record Librarians of North America at its recent convention in Detroit fills an important need of record librarians and hospital superintendents, according to Edith M. Robbins, chairman, board of registration. While the association provides for the registration of properly trained librarians, it refuses to act as an employment agency.

Members of the association who are in good standing may register without examination within one year after the establishment of the registry. Newly trained record librarians may register after submitting evidence of proper character and after passing the board of registration's examination. A certificate of registration will be issued to each approved candidate.

Record librarians are urged to communicate with the registrar, Evelyn Vredenburg, Woman's Hospital, New York City, for full particulars.

NEWS OF THE MONTH (Cont'd)

A. H. A. Appeals to R. F. C. to Aid Hospitals

An appeal to the Reconstruction Finance Corporation to extend its resources to hospitals of the country not receiving help from tax sources, that charity patients may be accommodated and many of the institutions saved from closing, was directed recently by the American Hospital Association, through its executive secretary, Dr. Bert W. Caldwell, to Senator Atlee Pomerene, chairman of the R. F. C.

Doctor Caldwell's letter points out that the 1,556 hospitals that are members of the association, which receive no tax revenue, have admitted and cared for 5,500,000 out of the 7,156,000 patients admitted to all hospitals in this country during the last year. His letter states that during the last two years these hospitals have devoted 33 1/3 per cent of their disbursements to the care of non-paying patients.

"So serious is the situation," he explains, "that in 1931, 110 voluntary hospitals closed their doors for lack of funds, and from January 1 to December 1, 1932, 162 of these hospitals have closed."

Hospital Offers Special Course in Tuberculosis Nursing

Montefiore Hospital for Chronic Diseases, New York City, which recently closed its nursing school because of the economic situation, has announced that it will conduct a postgraduate course for graduate nurses in the nursing care of tuberculous patients.

The course will cover a period of six months, one month of which will be spent in the Montefiore County Sanatorium.

University Hospital Executives Council Is Formed

Announcement has been made of the formation of a new organization known as the University Hospital Executives Council. The organization is made up of executive officers of hospitals under university control. The council's objects are to collect, digest and distribute specific data concerning the operating policies, the income and the costs for the various hospitals in the organization.

The officers for the first year are: president, Robert E. Neff, superintendent, University of Iowa Hospital, Iowa City, Iowa; vice president, Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison; treasurer, Dr. Harley A. Haynes, director, University Hospital, Ann Arbor, Mich., and secretary, John C. Dinsmore, superintendent, University of Chicago Clinics.

Record Librarians Hold Meeting in Chicago

The Association of Record Librarians of Chicago and Cook County met in Chicago on November 29. The feature event of the meeting was a round table discussion on the "Standard Classified Nomenclature of Disease," which was opened by Marguerite Simmons, Ravenswood Hospital, Chicago.

Adopt Plan to Care for Indigent Sick

A contract to care for indigent aged and afflicted persons was made recently between the Central Hospital Council, Saginaw, Mich., and the Saginaw County Medical Society, upon the authorization of the Saginaw board of supervisors.

The plan, which was one of the recommendations of a special economy committee, is expected to result in a saving to the county of $15,000 annually.

Submitted by the Saginaw General, St. Luke's and St. Mary's Hospitals, Saginaw, the plan is said to offer care for indigent and afflicted persons at the special rates of $2.70 a day for the first $10,000 of county business, at a discount of 15 per cent for the second $10,000 and at a discount of 20 per cent for the third $10,000.

The medical society will care for patients at the hospital for 25 per cent of the hospital bill. It will establish clinics at each hospital to be conducted one day each week with a clinic director in charge. Treatment and examination are to be given at the clinics, the former at $1 each exclusive of materials used, and the latter at $5 each. If persons are later sent to the state hospital at Ann Arbor, no additional examination fee will be charged.

PERSONALS

DR. R. O. HAWTHORNE, superintendent, Kankakee State Hospital, Kankakee, Ill., recently resigned his position and has resumed his private medical practice at Monticello, Ill.

LOUISE A. WHELPLEY is now superintendent, Community Hospital, Geneva, Ohio.

EMANUEL SCHWARZ, formerly superintendent, Newark Beth Israel Hospital, Newark, N. J., died recently of heart disease. He was seventy-three years of age.

W. C. LYNCH, for the past five years a member of the board of trustees, El Paso Masonic Hospital, El Paso, Tex., recently assumed the superintendency of the institution.

MRS. C. A. MILLAR was recently appointed superintendent, Virden Hospital, Virden, Man., Canada.

DR. PORTER E. WILLIAMS, superintendent, Kansas City General Hospital, Kansas City, Mo., died on November 18, following a seven weeks' illness. DOCTOR WILLIAMS was appointed superintendent, State Hospital No. 1, Fulton, Mo., in 1905, where he served for four years. He engaged in private practice for a number of years and in 1917 was named superintendent, State Hospital No. 2, St. Joseph, Mo., where he served until 1925, with the exception of two years as superintendent, State Hospital No. 3, Nevada, Mo. DOCTOR WILLIAMS was named head of Kansas City General Hospital in 1926. His successor in the superintendency of the Kansas City institution is DR. J. H. JENNETT.

JOHN S. MCCONNELL has resigned his position as superintendent, North Hudson Hospital, Weehawken, N. J.

Y. EDITH SANSOM is the new superintendent, Hale-Willard Memorial Hospital, Anna, Ill.

DR. CHARLES GORST, Madison, Wis., formerly superintendent, Wisconsin State Hospital for the Insane, Mendota, died recently. DOCTOR GORST served as head of the state hospital from 1904 until his retirement in 1915. He was seventy-nine years of age at the time of his death.

NELLIE M. HARDING was recently appointed superintendent, Bartow General Hospital, Bartow, Fla., succeeding DR. C. J. HURLBUT.

LILLIAN STERN has assumed the superintendency of Park City Hospital, Inc., Bridgeport, Conn.

GEORGE W. OLSON, formerly superintendent, California Hospital, Los Angeles, has received the appointment of assistant superintendent, Los Angeles County General Hospital, Los Angeles.

MADELINE I. LUNDGREN has recently been appointed superintendent of nurses, Easton Hospital, Easton, Pa.

DR. ALEXANDER JOHN MCRAE, Miami, Fla., has been appointed superintendent of the new Nassau County Hospital, Mineola, Long Island, N. Y., which it is expected will be completed about September 1, 1933.

DR. D. D. TODOROVIC was recently appointed superintendent, Dorris Hospital, Dorris, Calif.

ADDIE M. PERRY, for the past six years superintendent, Appalachian Hospital, Johnson City, Tenn., has been named superintendent, Asheville Mission Hospital, Asheville, N. C.

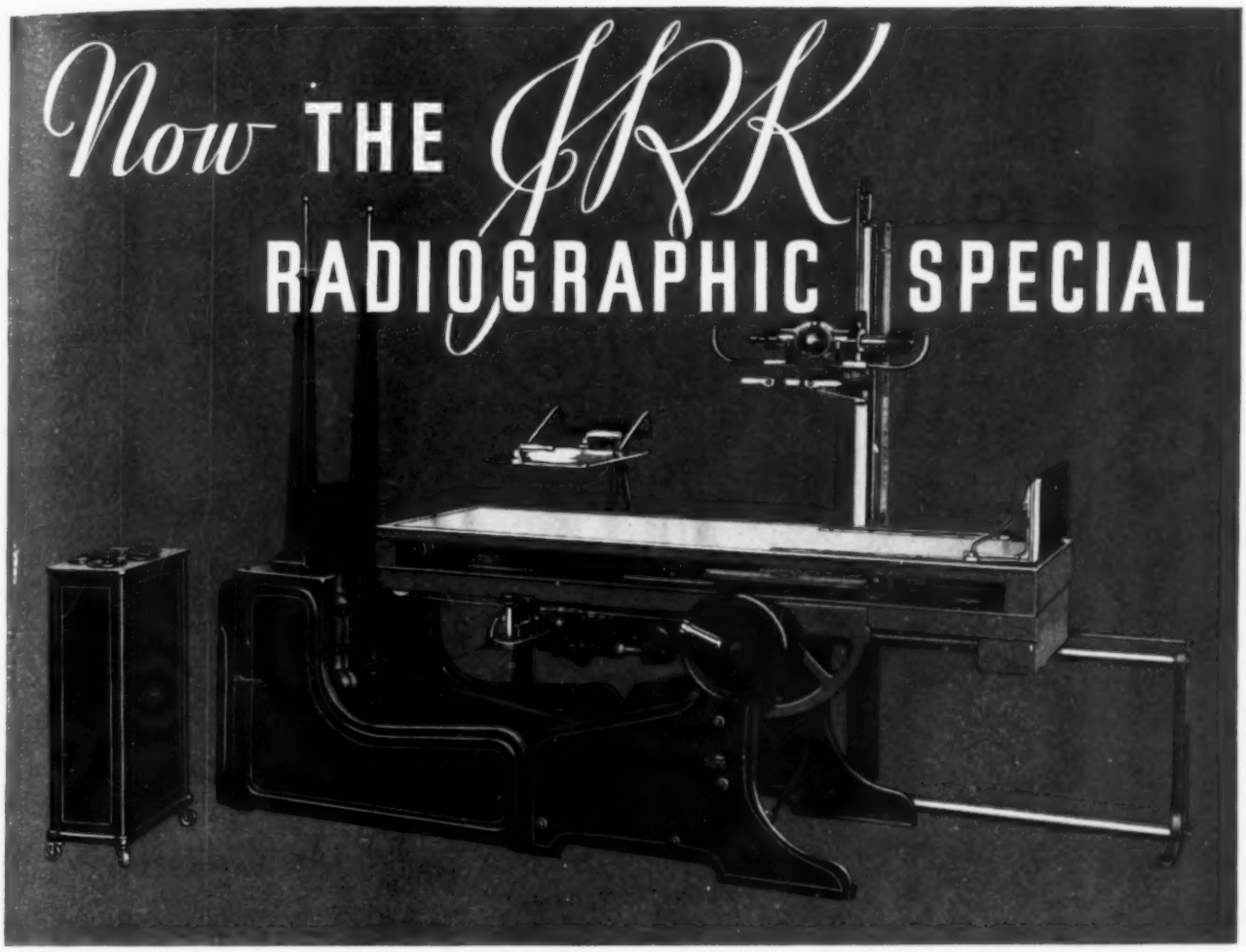
HELEN SCOTT HAY, famous World War nurse and Red Cross worker, died on November 25, at Savanna, Ill. For her work in establishing a training school for nurses at the request of the queen of Bulgaria, MISS HAY was given the decoration of the first order by the Bulgarian Red Cross. After the war MISS HAY was appointed director of American nursing in Europe, with headquarters in Paris.

LILLIAN D. BOUSKA has resigned as superintendent, Waseca Memorial Hospital, Waseca, Minn. SADIE FOX is the new superintendent of the institution.

DR. GEORGE A. SMITH, superintendent, Central Islip State Hospital, Central Islip, N. Y., is retiring because of the age limit. DOCTOR SMITH, who was seventy-four years of age on November 9, has been in the service of the institution for many years.

ELOISE P. QUICK has been appointed superintendent, Ideal Hospital, Endicott, N. Y. MRS. QUICK was formerly superintendent of nurses at the hospital.

MISS P. H. BRAITHWAITE, Baltimore, has been appointed superintendent, Chicago Lying-in Hospital and Dispensary, Chicago. MISS BRAITHWAITE



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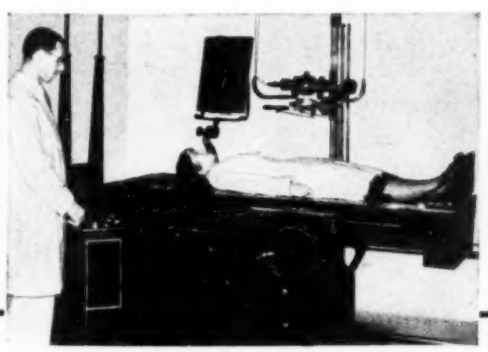

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PERSONALS

brings to her work a background of experience in community health work as well as special training and experience in university hospital organization and administration. She succeeds JESSIE CHRISTIE, who resigned September 1 after serving as superintendent of the institution for eighteen years.

DR. LIONEL E. HOOPER has been named superintendent of the new U. S. Marine Hospital, Seattle, Wash., which it is expected will be occupied in January.

Council on Medical Education and Hospitals Announces Program

A number of topics of interest to hospital executives are included on the program for the annual congress of the Council on Medical Education and Hospitals of the American Medical Association, which will be held in Chicago, February 13 and 14. The congress will be held in the Palmer House. The Federation of State Medical Boards of the United States and the American Conference on Hospital Service will participate in the congress.

Dr. Ray Lyman Wilbur, Washington, D. C., will preside at the opening session on Monday morning. Doctor Wilbur, who is chairman of the council, will render his report at this session.

There will be a joint session of the Council on Medical Education and Hospitals and the Federation of State Medical Boards on Monday afternoon, covering "Recognition of Specialists."

On Tuesday morning there will be a joint meeting of the council and the American Conference on Hospital Service, and the subject of nursing will be discussed. Dr. Harry E. Mock, Chicago, president, American Conference on Hospital Service, will preside. Among the topics and the speakers on the program for this session are: "Nursing Education and Nursing Service," Effie J. Taylor, New Haven, Conn., president, National League of Nursing Education; "Cost of Nursing Service and Nursing Education," C. Rufus Rorem, associate for medical services, Julius Rosenwald Fund, Chicago; "The Function of the Nurse as Defined by the Physician," Dr. George H. Coleman, Chicago. Another topic that will be discussed is "Nursing as Related to Hospital Administration."

The Federation of State Medical Boards will also hold a meeting on Tuesday morning, presided over by its president, Dr. Thomas J. Crowe, Dallas, Tex.

"Future Trends in Nursing" will be discussed by Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, at a luncheon meeting of the Central Council for Nursing Education on Tuesday.

For those interested in obtaining reduced rates to Chicago, the American Medical Association gives the following information:

"In order to obtain the reduced rate of one and one-half fares for the round trip to Chicago, it will be necessary to secure at least 100 receipts showing that full fares have been paid on the trip to Chicago. The reduced rates, if enough receipts are secured, will apply to friends and relatives as well as to those regularly invited to the congress.

"Be sure to obtain a certificate receipt for your fare to Chicago."

Hospital Bills Payable in Installments

The Hospital for Ruptured and Crippled, New York City, has announced the adoption of an extension of the deferred payment plan to cover hospital expenses.

Joseph D. Flick, superintendent, states that this is the same plan that has been approved by the Medical Society of the County of New York, and that patients will be given ten months' time in which to pay their hospital bills, plus an interest charge.

The staff of the hospital has been notified that the hospital bill and the doctor's bill can be consolidated into one obligation under this plan, if they so desire.

Dietetic Group Announces New Officers

The following officers were elected at the annual meeting of the American Dietetic Association, held recently in New York City: president, Dr. Kate Daum, University of Iowa Hospital, Iowa City; president-elect, Quindara O. Dodge, Women's Industrial and Educational Union, Boston; secretary, Margaret Ritchie, Battle Creek College, Battle Creek, Mich.; treasurer, Ella M. Eck, Albert Merritt Billings Hospital, Chicago.

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Palmolive is the beauty soap patients expect in your hospital

NOW you can see why patients expect Palmolive in your hospital . . . why they appreciate it! The test tube on the right shows the exact amount of olive oil that goes into each cake. This is the reason your patients can be sure of Palmolive. They know what Palmolive is made of. They know the value of olive oil in soap. Doubtless this is responsible for the fact that more people use Palmolive than any other soap—responsible, too, for the fact that more than 20,000 beauty experts recommend its use.

Yet in spite of its quality and prestige, Palmolive costs no more than ordinary soaps. Your hospital's name printed on the wrappers with orders of 1,000 cakes or more. Mail the coupon today for our new free building cleanliness booklet and prices of Palmolive Soap in the five special sizes for hospitals.

This much OLIVE OIL *goes into each cake of Palmolive*

SUPER SUDS *for hospital laboratory use*

Letters from hospital laboratory directors and nurses prove this new bead soap ideal to clean laboratory glassware, hospital instruments, utensils and equipment. *Super Suds* cleans quickly, easily, efficiently. It leaves bottles, slides, everything, bright, clean, sparkling! Mail coupon for complete information.

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NEWS OF THE MONTH (Cont'd)

International Hospital Congress Will Meet in Belgium

The thirteenth International Hospital Congress will meet in Knock, Belgium, June 28 to July 3. The study committees of the International Hospital Association will submit their reports to the congress previous to the meeting, and discussions will enable the congress to draw the outlines of practical conclusions having an international value.

During the fall of last year the association held postgraduate courses on hospital technique at the Frankfort Municipal Hospital, Frankfort, Germany, which were attended by hospital administrators from seventeen different countries.

Technicians' Registry Announces Examination for Applicants

The Registry of Technicians of the American Society of Clinical Pathologists has announced that beginning April 1, applicants to the registry must pass an examination conducted by a member of the society practicing in the locality in which the applicant resides.

This examination will comprise: (1) an oral and practical test, counting 50 per cent; (2) a written test, counting 25 per cent, and (3) personal and psychological attributes, counting 25 per cent.

The fee for registration has been increased to $10. A certificate of registration will be issued to all applicants accepted by the registry.

Newark Launches Group Insurance Plan for Hospitalization

The Associated Hospitals of Essex County, Inc., has been duly incorporated at Newark, N. J., for the purpose of participating in a plan of group insurance for the hospital care of patients. It is expected that the plan will be under way January 1, according to Frank Van Dyk, executive secretary of the new enterprise which has for its officers the executive committee of the Hospital Council of Essex County.

Associated Hospitals has entered into a contract with a group of Newark business and insurance men who will handle the group sales under the supervision and direction of the hospital interests. Associated Hospitals agrees to pay participating hospitals who render service under the terms set forth, on the basis of $6 a day a patient.

New Embree Book Talks of Way to Happiness

Edwin R. Embree, president of the Julius Rosenwald Fund and author of "Brown America," has recently published "Prospecting for Heaven,"[1] a striking contribution to the literature of the mental and social sciences. The book takes the form of a series of stimulating and searching conversations supposed to have taken place between seven men and a girl on four evenings in a hotel room.

Mr. Embree presents in these conversations, which are directed by himself, an interpretation of the universe as it now is, seen through the eyes of these various persons. The talkers discuss questions of love and happiness and the future of society in their relation to man's mastery over the physical world which has brought him a new leisure. "The most conspicuous crossroads at which man stands today," it is pointed out, "is whether he will follow the age-old habit of drudging work or will take advantage of the new leisure which machine production should make possible. Strange as it may seem it is by no means certain that man can bring himself to rest from his labors."

Can science harness Heaven? This is the book's fascinating theme and its treatment is novel and intriguing. Mr. Embree makes a strong plea for the enriching of the human life which research and medicine have succeeded in prolonging.

The persons participating in this unusual method of philosophizing are a psychiatrist, a world sanitarian, a psychologist, a psychoanalist, a social scientist, an intelligent young woman, the author and a mythical Chinese philosopher, all of whom have endorsed the author's use of their often expressed views.

Mr. Embree sailed in December for the Dutch East Indies where he will make a study of schools in that part of the world. During his six months' absence, Dr. Franklin C. McLean, formerly director of the University of Chicago Clinics, will serve as acting president of the Julius Rosenwald Fund.

[1] The Viking Press, New York City.

"The suprarenalin Miss Gray,—ARMOUR'S"

"Is the patient ready? And will you get me the suprarenalin, Miss Gray? Armour's."

Armour's Suprarenalin Solution is unqualifiedly recommended for producing a bloodless field for minor operations. It is dependable because of its *maximum and unvarying potency*—obtained by the cautious selection of fresh glands from a vast daily supply, and immediate processing, while the animal heat is still retained. Thirty-five years have not found one Armour product wanting in potency.

For maximum and unvarying potency, always specify Armour's when prescribing Pituitary Liquid (Obstetrical), Surgical Ligatures, Concentrated Liver Extract, and Concentrated Liver Extract with Iron.

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HEADQUARTERS FOR MEDICAL SUPPLIES OF ANIMAL ORIGIN

Doctor MacEachern to Head Public Relations Committee

Dr. George F. Stephens, president, American Hospital Association, has announced the appointment of the public relations committee of the association.

Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, has been named chairman, and already plans are being formulated for presentation of a nationwide public relations campaign which will embrace every type of community contact. Doctor MacEachern will form subcommittees and additional associate committees under the direction of the general committee, and if the plans now being considered are put into effect hospitals will receive considerable favorable attention during the next year. Public speaking and releases to publications will be a big part of the general committee's work and hospitals will be kept informed from month to month of the developments.

The other members named on the committee are John A. McNamara, THE MODERN HOSPITAL, Chicago, secretary; Dr. G. Harvey Agnew, hospital division, Canadian Medical Association, Toronto, Ont.; Mrs. Lola M. Armstrong, *Western Hospital Review*, Los Angeles; Dr. B. W. Black, Highland Hospital, Oakland, Calif.; Dr. Louis H. Burlingham, Barnes Hospital, St. Louis; General Hugh S. Cumming, surgeon general, U. S. Public Health Service, Washington, D. C.; Dr. Michael M. Davis, Julius Rosenwald Fund, Chicago; Dr. Joseph C. Doane, Jewish Hospital, Philadelphia; Paul H. Fesler, Wesley Memorial Hospital, Chicago; Matthew O. Foley, *Hospital Management*, Chicago; Dr. S. S. Goldwater, New York City; Ethel Johns, New York Hospital, New York City; Robert Jolly, Memorial Hospital, Houston, Tex.; Alfred C. Meyer, president, board of trustees, Michael Reese Hospital, Chicago; Dr. Christopher G. Parnall, Rochester General Hospital, Rochester, N. Y.; Mary M. Roberts, *American Journal of Nursing*, New York City; Homer F. Sanger, American Medical Association, Chicago; Rev. Alphonse Schwitalla, Catholic Hospital Association, St. Louis; Dr. Lewis A. Sexton, Hartford Hospital, Hartford, Conn.

Will Maintain Clinic and Exhibit at Chicago's World Fair

An exhibit and clinic on the care of the crippled child will be held at A Century of Progress Exposition, Chicago, in 1933, by the Home for Destitute Crippled Children, Chicago. The exhibit will be registered jointly under the name of the home and the University of Chicago.

Alien Employees Dismissed From New York Hospitals

It was announced on December 3 by Dr. J. G. William Greeff, commissioner of hospitals, that all nurses, orderlies, helpers and other paid employees in New York City's twenty-seven hospitals who are not American citizens would be dismissed. Doctor Greeff stated that this was part of the general economy plan in the city departments, and that it would affect between 800 and 1,000 persons. He stated further that when these jobs were filled again American citizenship would be required of all those who were employed.

Several similar movements have been on foot in this country both in hospitals and elsewhere, reports having come from San Francisco, Los Angeles and some other cities of the Pacific Coast.

Coming Meetings

Hospital Association of the State of Illinois.
President, J. Dewey Lutes, Ravenswood Hospital, Chicago.
Secretary, E. I. Erickson, Augustana Hospital, Chicago.
Next meeting, Chicago, May 3-5.

Indiana Hospital Association.
President, George William Wolf, Lafayette Home Hospital, Lafayette.
Secretary, Gladys Brandt, Cass County Hospital, Logansport.
Next meeting, Chicago, May 3-5.

Iowa Hospital Association.
President, Clinton F. Smith, Allen Memorial Hospital, Waterloo.
Secretary, E. C. Pohlman, University Hospital, Iowa City.
Next meeting, Marshalltown, April 19-20.

National Methodist Association of Hospitals, Homes and Deaconess Work.
President, Rev. John G. Benson, Methodist Hospital, Indianapolis.
Secretary, G. M. Hanner, Beth-El Hospital, Colorado, Springs, Colo.
Next meeting, Indianapolis, Feb. 15-16.

New England Hospital Association.
President, Bertha W. Allen, Newton Hospital, Newton, Mass.
Secretary, Dr. Albert G. Engelbach, Massachusetts General Hospital, Boston.
Next meeting, Boston, Feb. 17-18.

Hospital Association of Pennsylvania.
President, John M. Smith, Hahnemann Hospital, Philadelphia.
Secretary, Howard E. Bishop, Robert Packer Hospital, Sayre.
Next meeting, Philadelphia, March 21-23.

Western Hospital Association.
President, Dr. B. W. Black, Highland Hospital, Oakland, Calif.
Secretary, Lola M. Armstrong, *Western Hospital Review*, Los Angeles.
Next meeting, Long Beach, Calif., Feb. 22-25.

Wisconsin Hospital Association.
President, Dr. R. C. Buerki, Wisconsin General Hospital, Madison.
Secretary, George Crownhart, State Medical Society, Madison.
Next meeting, Chicago, May 3-5.

Kitchen of Englewood Hospital
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Modern Hospital installs
GARLAND

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Top surface, 34 x 40½ inches. Oven, 24 x 28 x 15 inches. Other top constructions to meet every cooking requirement.

Check these Important Features:

1. Smooth front . . . manifold, hinges, and door springs are concealed . . . sanitary and appealing
2. All hot top . . . heated by nine single jet burners forming a solid sheet of flame under entire top, with perfect combustion
3. Heavy 1½ inch insulation around oven . . . cuts fuel costs . . . keeps kitchen cool
4. Balanced oven door . . . extra heavy, will not warp
5. Enameled oven linings . . . very easily kept clean, will not rust
6. Cool valve handles . . . cool oven door handle
7. Oven heat control (optional) reduces fuel costs . . . controls heat at any temperature required, bake or roast with but little attention

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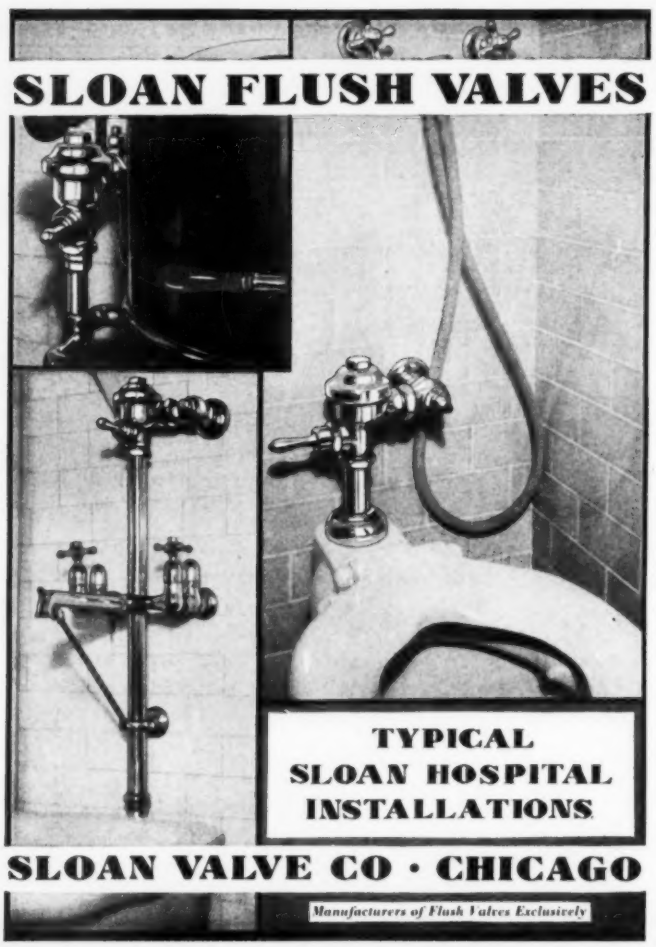


New York Hospitals Consider Group Insurance Plan

An insurance plan for hospitalization of gainfully employed groups was discussed at a recent meeting of the Hospital Conference of New York City.

A committee was appointed to meet with representatives of the United Hospital Fund of New York to study the merits of group hospitalization insurance and to determine whether an insurance plan of the type suggested is feasible for adoption in New York City. The plan which has been suggested provides for a pay roll reduction of $0.85 a month for the hospital insurance premium. The insurance will provide a maximum of twenty-one days care in semiprivate accommodations, including nursing, use of the operating room, laboratory, x-ray, anesthetics, drugs and dressings.

Physicians' and surgeons' fees are not included in the plan.

"Don't Build Any More Hospitals," Hines Tells Government

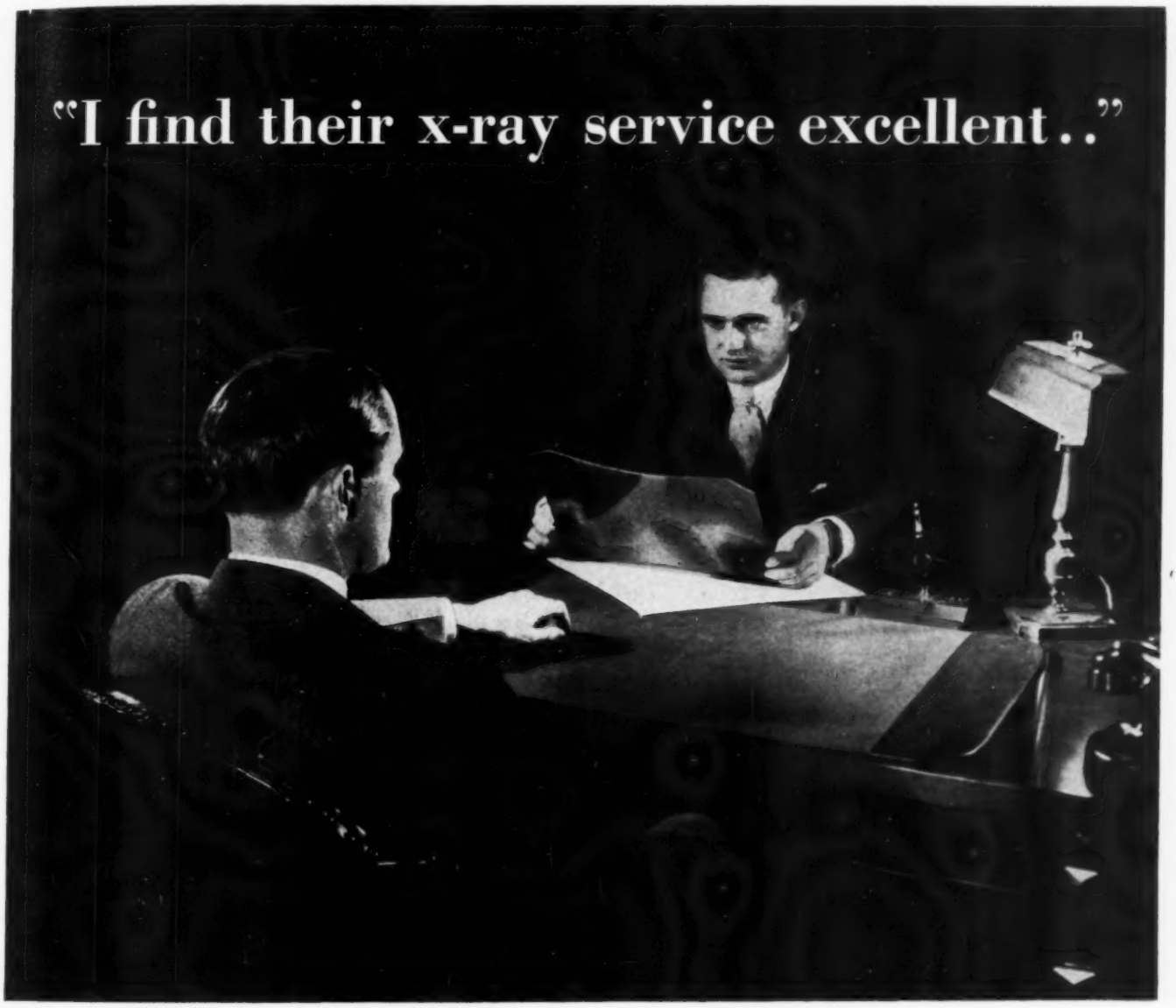
Recommendations for changes in veterans' relief laws affecting hospitalization, domiciliary care and insurance, which would effect an annual saving of approximately $11,500,000, were made December 15 to the congressional joint committee studying veterans' laws by Brig. Gen. Frank T. Hines, administrator of veterans' affairs.

Additional construction to care for the peak load in hospitalization up to 1965, General Hines told the committee, would approximate $160,388,000, which with the operating costs would swell the total to about $1,203,000,000.

In view of this additional cost, he recommended adoption of a policy of extending existing facilities rather than constructing new units. Otherwise, following the period of the peak load in hospitalization, the government will have on its hands large institutions with empty beds, he added.

Questioned by Senator Hatfield (Rep.) of West Virginia, as to what part of the hospital load might be borne by civilian rather than government hospitals, General Hines pointed out that private institutions could and should absorb those cases of the nonservice group where the veteran is able to pay for his hospitalization. Civilian hospitals are not interested in charity cases, he added.

In government institutions preference should be given those who are unable to pay for hospital care, and then only after service connected cases are cared for, General Hines said. Provision should be made in the law that those who are able to pay for their care should not be given free hospitalization, he recommended.



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Uniform Films—Pure Chemicals

The films are constantly uniform . . . have maximum sensitivity. The chemicals are of the utmost purity. Together, they provide the basis for complete standardization. For the highest quality results as well as the avoidance of waste, use them exclusively. Eastman Kodak Company, *Medical Division*, Rochester, New York.

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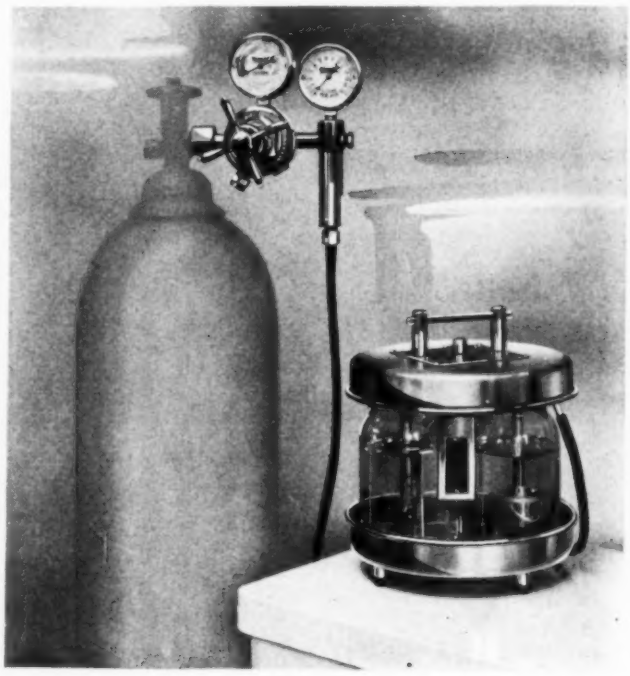
NEWS FROM MANUFACTURERS

THE WISCONSIN OXYGEN HUMIDIFIER

For the purpose of ensuring maximum comfort and safety to the patient receiving oxygen therapy by the nasal catheter method, Scanlan-Morris Company, Madison, Wis., announces the oxygen humidifier illustrated below.

The apparatus consists of a humidifying jar, a flow gauge, and a water trap. Rubber tubes connect the humidifier to the oxygen cylinder and to the catheter. The bubbles of oxygen pass through the humidifying jar, are broken up by porcelain beads in the mixing chamber and pick up all the moisture possible. Passing next through the flow gauge jar, the gauge indicates in approximate liters per minute the flow of oxygen and serves as an additional check on the cylinder flow gauge. The third jar acts as a moisture trap to collect drops of water which might be carried over.

Quart size Mason jars are used to permit quick replacement in case of breakage. These jars screw into standard



screw tops fastened to the cover of the humidifier. The jars, with necessary connections, are bolted to a metal tray, 9 inches in diameter, fitted with short rubber feet. A convenient carrying handle is supplied. Metal parts are finished in chrome plate. This equipment is described by the manufacturer as of simple design and construction, easy to operate, economical, readily portable and safe. It requires little supervision in use.

WILL DEAL IN FLOOR CLEANING GOODS

Wilson and Buster, Inc., is the name of a new firm that has been organized in Kansas City, Mo., to deal in floor cleaning materials and services for hospitals, schools and other buildings. The firm is composed of A. Reed Wilson and D. Hugh Buster, both formerly with the Vestal Chemical Co., St. Louis.

New FAULTLESS Expansion Socket

will never deteriorate with age

THE new Faultless Rockite Expansion Socket is the very *latest* development in improved caster equipment and the finest caster socket on the market for use in hospitals. It is a new *expanding* socket that offers new features never before found in a product of this kind. Because it can be expanded as much as $\frac{3}{16}$ of an inch, it may be made to fit the leg of any piece of metal furniture, regardless of varying thicknesses of metal.

Never deteriorate with age

The expanding segments of this new socket are made of *Rockite*, a *hard, composition* material, instead of soft rubber. Rockite will never "set" to the shape of the tubing and will never deteriorate with age. It cannot rust . . . is not affected by water, heat, cold, atmospheric conditions or cleaning fluids. The entire expanding mechanism is simply and sturdily built. There are no complicated parts to get out of order.

Casters easily detached

In cases of emergency, when beds need to be elevated, casters may be instantly detached from this new expansion socket. Either double ball bearing or pivot bearing casters may be used.

Write for New Catalog

Before you buy new or replacement caster equipment, by all means get detailed information about this new, improved Faultless Rockite Expansion Socket. Write for our new Catalog LD — which will be mailed promptly without charge or obligation.

FAULTLESS CASTER COMPANY, EVANSVILLE, IND.
BOSTON—CHICAGO—DETROIT—GRAND RAPIDS—NEW YORK
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CANADIAN FACTORY: STRATFORD, ONTARIO

NOELTING
FAULTLESS
CASTERS

Contains no soft rubber . . . fits all sizes of metal furniture legs . . . has no complicated parts to get out of order.

No Special Tools Needed to Install

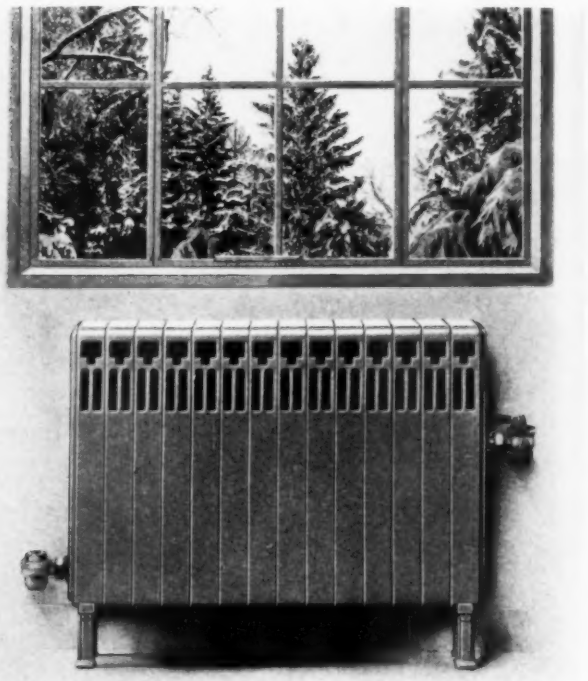
No special wrenches are ever needed to install or remove this socket. A few turns of expansion nut A with any ordinary wrench—and the job is done. The entire circumference of the socket expands against the inside of the tubing, giving a *positive, non-slip* grip. Sockets can be easily removed and placed in another bed (or other metal furniture) having legs of the same or different size.

MAKERS OF QUALITY CASTERS SINCE 1890

A RADIATOR, CABINET AND GRILLE

A new principle in radiator construction makes the Shaw Radiator, manufactured by the Shaw-Perkins Manufacturing Co., Pittsburgh, a combined cabinet, grille and radiator. This radiator comprises an extended surface steel structure in contact with various numbers of horizontal runs of internal copper tubing which form the heating coil. All surfaces are in heat contact with the copper tubing so that the radiator supplies both convected and radiant heat.

The radiator is compact, varying in size from 14 to 23 inches in height, and from 11 to 71 inches in length. It is



3 inches wide. The air outlets are located either in the top or in the front panel.

The radiator may be installed fully exposed upon wall brackets or legs, thus providing its own cabinet; it may be recessed into the wall, with the front panel serving as an inclosure and a grille, or it may be installed as a convector within an ordinary recessed inclosure.

The outside surfaces of the radiator may be wiped clean with a rag, while the interior, also of smooth flat surfaces may be cleaned through the bottom by vacuum cleaner.

COLORED INLAYS ADDED TO TRAYS

Smartly colored metal inlays have been added to the line of Micarta trays made by the Westinghouse Electric and Manufacturing Co., East Pittsburgh. The five designs, made by George Switzer, New York artist, are modern interpretations of authentic period decoration. These trays are designed to harmonize with Early American, French Provincial, Chippendale, and other eighteenth century designs, as well as with modern interiors.

The designs are named Nocturne, a romantic fantasy of the moon, the stars, the sea and ships; Tribal Prayer, inspired by the Indian designs of the Southwest; First Empire, with the Napoleonic military arrow, the laurel of victory and the star of the empire; Marco Polo, reflecting the Chinese influence, and Dynamique, where modern power, motion and speed are symbolized by the airplane, the racing car and the speed boat.

These trays are heat and acid resisting the same as the plain Micarta trays.

These 5 Vulcan Features CUT COOKING COSTS

5 *Cost-Cutting Examples*

•

Over Gas

$400 a month saved in fuel alone by replacement of obsolete equipment by a hotel. Savings paid for equipment in 8 months.

•

Over Electricity

$388 cut in fuel bill first month by Club which changed to Vulcan gas equipment.

•

Over Electricity

$219 average monthly saving by hotel installing new Vulcan equipment.

•

Over Electricity

$810 saved in first three months by hotel after change to Vulcan gas equipment . . . with 35% increase in business.

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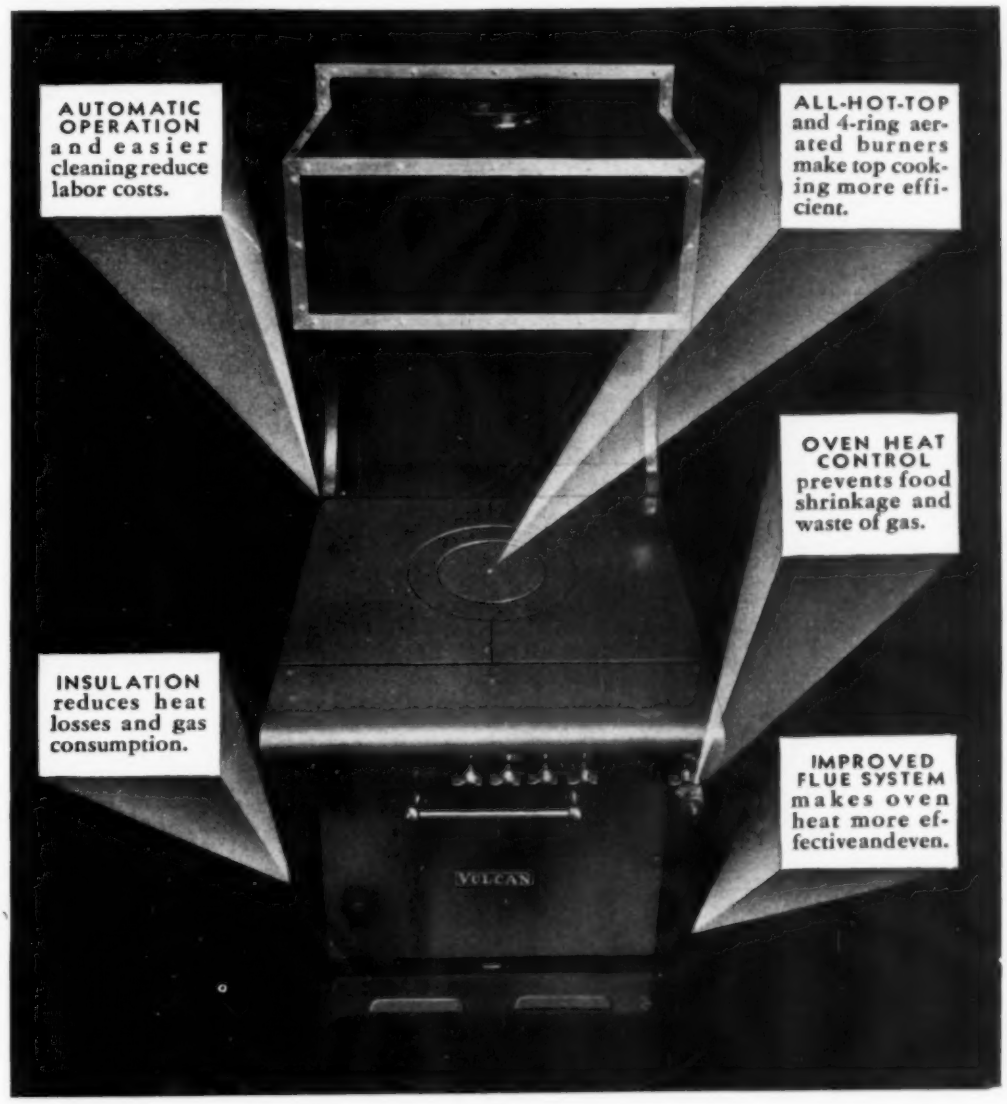
Over Oil

$140 monthly saving in fuel and upkeep by installation of Vulcan. Gas cost per meal 1/10 cent.



"CUT COSTS" is the order of the day. Yet service and quality must be maintained.

Cooking operations frequently offer the greatest opportunity to cut costs without sacrificing service features. See column above for examples of savings made by replacing obsolete gas equipment or other fuels with latest Vulcan gas equipment.

Vulcan cooking equipment pays for itself in savings alone. Eight months' savings paid entire cost of new Vulcan equipment in one hotel!

Whether you operate a hotel, restaurant, hospital, club or school kitchen, it will pay you to investigate the savings made possible by new Vulcan equipment. ASK FOR COST-CUTTING QUESTIONNAIRE SHEET.

STANDARD GAS EQUIPMENT CORPORATION, 20 East 41st Street, NEW YORK CITY, New York

Baltimore, Chicago, Boston, Birmingham—*Pacific Coast Distributor:* Northwest Gas & Electric Equipment Co., Portland, Oregon

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VULCAN EQUIPMENT MAKES GAS THE MODERN EFFICIENCY FUEL . . . CLEAN, FAST AND ECONOMICAL